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ABSTRACT

This is the final report on the first year evaluation of the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program that was initiated by the Office of Child Development OCD/HEW in 1974. In initiating the program, OCD/HEW set forth the following objectives: (1) to assess the benefits in terms of increased services for both Head Start and non-Head Start children and to establish the dollar value of these services; (2) to determine any barriers which prevent the Head Start program from making maximum use of Medicaid, EPSDT to pay for required health services provided to Medicaid eligible children in local programs; and (3) to analyze long-term program and policy issues concerning Head Start services to young children as a basis for improving those services in Head Start/Medicaid EPSDT. This detailed report presents and analyzes data collected during the first year of the program and also sets forth key policy considerations based on study findings. Included are charts and tables. (Author/MS)

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FINAL REPORT:

HEAD START/EPSDT COLLABORATION EVALUATION

CONTRACT NO. 105-74-1101

Prepared for:

OFFICE OF CHILD DEVELOPMENT

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INTRODUCTION

This is the final report on the first year evaluation of the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program that was initiated by the Office of Child Development (OCD)/HEW in 1974. In initiating the program, OCD/HEW set forth the following objectives:

- to assess the benefits in terms of increased services for both Head Start and non-Head Start children and to establish the dollar value of these services
- to determine any barriers which prevent the Head Start program from making maximum use of Medicaid/EPSDT to pay for required health services provided to Medicaid eligible children in local prograams
- to analyze long-term program and policy issues concerning Head Start services to young children as a basis for improving those services in Head Start/Medicaid EPSDT.

This report, which has been prepared by Boone, Young & Associates, a private consulting firm under contract with OCD/HEW to evaluate the Head Start/EPSDT Collaborative Effort, presents and analyzes data collected during the first year of the program. It also sets forth key policy considerations based on study findings.

In evaluating the collaborative effort, the report examines the effectiveness of the program strategies chosen by participating projects, and through this evaluation, seeks to provide direction for policy and program planning.

The interim report provided a detailed analysis of the programs prior to the initiation of the collaborative effort, and included in-depth tabular compilations. The final report discusses the history of Head Start and EPSDT only insofar as they have a bearing on the collaborative effort. Likewise, only those tables and data analyses germane to the evaluation, key findings, and policy considerations are included here. Readers wishing a more comprehensive overview of the Head Start and EPSDT programs and a more inclusive presentation of study data are requested to consult the interim report. All tables presented in the interim report are included in the final report as Appendix A.

Boone, Young & Associates wishes to extend its gratitude to the OCD staff for its cooperation in implementing the evaluation study design. We also wish to expressly thank the staff of the funded projects, without whose cooperation this study could not have progressed.

ORGANIZATION OF THE FINAL REPORT

Section I presents a summary of the major findings, crucial problems, and key policy considerations ascertained from the study by specific issue area.

Section II presents background information on the EPSDT and Head Start Programs and the Collaborative Effort.

Section III describes the study methodology employed in the evaluation.

Section IV discusses the organization and operation of the Head Start/EPSDT Collaborative Effort.

Section V examines Medicaid certification results and reviews prior health care status of participating children.

Section VI analyzes the provision of health services during the first year of the collaborative effort.

Section VII offers an analysis of the state EPSDT plans and compares these to the Head Start Program Performance Standards.

Section VIII cites the technical assistance needs of the projects.

Section IX provides cost utilization factors related to the collaborative effort.

Appendix A - Tables From Interim Report

Appendix B - Data Processing

Appendix C - Profile on IMPD Projects

I: SUMMARY OF MAJOR FINDINGS, CRUCIAL PROBLEMS AND KEY POLICY CONSIDERATIONS

This section summarizes the major findings of the first year evaluation of the Head Start/EPSDT Collaborative Effort and presents the crucial problems and key policy considerations for the following issue areas:

1. Medicaid certification for Head Start and non-Head Start children
2. Previous health care status of Head Start and non-Head Start children
3. Receipt of health services during the first year
4. EPSDT reimbursable services provided/obtained during the first year
5. Supportive services provided to non-Head Start children
6. Comparison of Head Start Program Performance Standards and State EPSDT Plans
7. Analysis of State EPSDT plans and providers' performance
8. Cost utilization factors pertaining to service delivery
9. Technical assistance needs of the projects and staff characteristics.

In assessing the first year evaluation, several conclusions may be drawn from the first year findings. First of all, the Head Start projects were reasonably successful in accomplishing the objectives of the collaborative effort. Many Head Start children were screened during the first year, even though they were not always Medicaid certified. Morever, in the projects selected for in-depth study, there was much concentrated effort to assure the completion of services.

Secondly, and on the positive side, Head Start programs initiated relationships with many public welfare, health and social service agencies, and private sector providers, and reinforced existing contact with such groups. In some target states, Head Start programs stimulated greater interest in EPSDT within local communities and among concerned state agencies.

The major objective of the collaborative effort was to increase health services to children ages 0-6 through effective utilization of the EPSDT program by Head Start. In order to accomplish this task, OCD awarded supplemental grants to 200 Head Start projects whose main responsibility would be to devise specific program strategies to carry out OCD's objectives. These grants were awarded on the basis of applications submitted by the programs which described the potential and actual Medicaid/EPSDT population within Head Start and the surrounding community, and their plans for mounting an effective collaborative effort. The projects selected constituted the national sample for the evaluation study. Thirty of these were selected for in-depth analysis.

The projects represented a wide spectrum of the national Head Start program but showed a strong rural bias despite the high incidence of Head Start programs in low-income urban areas generally. Many ethnic, cultural and linguistic groups, including blacks, Chicanos, American Indians, poor whites were part of the national sample. Also, specific Head Start projects--the Indian and migrant workers' demonstration projects (IMPD)--were included. The numbers of children receiving Head Start services in individual projects ranged from 60 to 2,500. In choosing the selected sample of thirty projects, efforts were made to insure that the selected group approximated the characteristics of the national sample with corrections for rural bias.

OCD established several priorities for these demonstration projects during the first year. The most important priority was to provide EPSDT services to as many Medicaid eligible Head Start children as possible and enroll in Medicaid the maximum numbers of Head Start children not yet certified by the medical assistance program. As a second priority, Head Start projects were to conduct community-wide recruiting for non-Head Start Medicaid eligible children. For this population, also, the projects were to assure certification of the Medicaid eligible children.

During the first year of the collaborative effort, the Head Start projects reached 129,234 Head Start and non-Head Start children. (This figure was calculated by extrapolating the total number of children reported screened, 95,997, by 147 projects to the universe of 198 programs that had received supplemental grants.) For children diagnosed or treated, the extrapolated number for the 198 programs is 26,933 children.

For the Head Start projects, the first year of operation for the collaborative effort was primarily a developmental period, with many trial and error learning experiences. During this period, the demonstration projects had to phase in the collaborative effort as well as familiarize themselves with the various forms being used in the evaluation study.

Many did not realize the potential for services to non-Head Start children through utilization of community resources. In some cases, too, the projects were stymied by the reaction of public agencies or the difficulty of intermeshing with the state EPSDT system. Reviewing the level of participation in terms of number of children against the generally limited technical support received by the demonstration projects, the level of activity--greatly varied among individual projects--is understandable and, in some instances, commendable.

The major findings and policy considerations, as well as crucial problems related to these, are detailed below by issue area.

Issue Area 1: The extent to which the projects achieved Medicaid certification for Head Start and non-Head Start children.

FINDINGS:

- Head Start projects were reasonably successful in reaching and reviewing children for Medicaid eligibility, but the majority of children--both Head Start and non-Head Start--who were reported as Medicaid certified began the EPSDT Collaborative Effort with that status (60%) (17,989 out of 25,737).

  The projects were more successful in reaching and reviewing non-Head Start children for Medicaid eligibility, but the majority of the non-Head Start youngsters were the siblings of Head Start enrollees who were already certified, rather than siblings in those Head Start families believed eligible but not yet certified.

- The projects were highly successful in obtaining Medicaid certification for non-Head Start children who had not been certified prior to entry into the collaboration (83%, or 10,178 out of 13,277). They were less successful with the Head Start population (30%, or 14,684 out of 38,912), reflecting possible discrepancies between the eligibility standards for Medicaid and Head Start.

- The parent involvement component was generally useful in providing for outreach, screening, and establishing Medicaid eligibility, particularly for the siblings of non-Head Start children.

- There were wide variations among regions and among selected projects in the numbers of children--Head Start and non-Head Start--for whom Medicaid certification was achieved.

PROBLEMS:

- Limited staff resources and the lack of clarity as to the degree of involvement by Head Start staff in the recruitment of non-Head Start, non-sibling children were apparently important adverse factors in reaching these children.
- The differences in eligibility standards for Medicaid and Head Start services may have affected the number of children who were found to be Medicaid eligible by the projects. States with appreciably low Medicaid standards may have been unable to accept low-income children recruited by the Head Start projects for the collaborative effort.
- Many children apparently experienced considerable fluctuation in their Medicaid status over the year, with possible detrimental results for health care continuity.

POLICY CONSIDERATIONS:

- Systematic planning, including reliable estimates of the number of children to be served and information on the type of supportive services available, would be likely to enhance certification efforts through improved deployment of staff resources.
- Local Head Start programs could use standardized procedures for assessing Medicaid eligibility by Head Start programs so that the accuracy of Medicaid certification referrals might be increased. Also, review

could be undertaken by OCD of barriers to EPSDT eligibility for Head Start enrollees because of some states' low-income criteria.

- Head Start programs could establish closer working relationships with local EPSDT agencies to speed the determination and certification process of a referral child.
- The number of potentially eligible children brought into EPSDT could be increased were the projects given greater assistance in developing outreach techniques, and were greater stress placed on the demonstrably successful parent involvement component.
- Because the income eligibility differences (in dollars) tend to be minimal between Medicaid and Head Start, OCD may wish to review with SRS the feasibility of providing Medicaid certification to low-income, preschool children on the basis of their enrollment in Head Start.

Issue Area 2: Previous health care status of Head Start and non-Head Start children.

FINDINGS:

- Nearly all of the previously enrolled Head Start children (92%, or 6,792 out of 7,343) had received screening services primarily through Head Start prior to entry into the EPSDT effort, and Medicaid certification or eligibility was not a factor in receipt of these services.
- Few projects reported children--Head Start or non-Head Start--who received mental health, medical, and nutritional services prior to entry into EPSDT.
- Non-Head Start children who had received health services prior to entering EPSDT were primarily Medicaid certified and siblings of Head Start enrollees.

PROBLEMS:

- The availability of various health services in a local area, with some communities apparently having significantly greater resources than others, may have determined the incidence of prior health care to some degree in any particular region.
- The similarity in incidence between Head Start and non-Head Start children who received screening services prior to EPSDT entry may reflect the concentration by some Head Start programs in providing family health services rather than focusing on the needs of the enrolled Head Start child, alone. Apparent emphasis in the projects on supplying dental services for Head Start enrollees may explain the relatively lower rate of dental care for non-Head Start children.

POLICY CONSIDERATIONS:

- Head Start programs might be encouraged to arrange for family health services, thereby ensuring that all family members, including children, are provided comprehensive care. Similarly, the projects could be assisted in defining their responsibility for recruiting participants beyond the immediate Head Start family as part of the Head Start performance standards.
- Limitations in some state plans for Medicaid/EPSDT could be overcome through implementation of national standards for the provision of health services to low-income, pre-school children.
- Greater assistance for Head Start programs in improving utilization of community health resources would result in expanded screening services through augmentation of the programs' own capabilities.
- Additional assistance for Head Start programs would enable them to become more aware of the overall developmental health of pre-school children. Particular stress could be placed on nutritional and mental health development.

Issue Area 3: The extent to which the projects provided/obtained health services for Head Start and non-Head Start children during the year.

FINDINGS:

- There was a fourfold increase in the number of children screened this year compared to last year. The vast majority of children screened (86%, or 82,782 out of 95,997) were Head Start enrollees. Most of these screenings, however, were incomplete at the time of reporting. Although there was an increase in the number of non-Head Start children screened, it was not as great.
- Although relatively large numbers of children were screened, only one out of five were diagnosed or treated. For those treated, acute or chronic care was most often provided for both Head Start and non-Head Start children; and each child received 2.6 units of treatment.

PROBLEMS:

- The availability of particular health services in a given area again influenced the incidence of their receipt this year, particularly psychological and nutritional services.
- The lack of information about the nature or quality of screening and other health services provided limits the assessment about the impact of these services upon the health status of the children.

- The relatively large number of Head Start children participating who were ineligible for Medicaid or of unknown status means that the Head Start projects most likely had to pay for services rendered from their own program resources, even if the services were available through the state EPSDT plan.

- As in the case of the previous year, dental care was the most prevalent type of health service provided. There was a fourfold increase in the number of children reported this year.

- More than 90% (8,800 out of 9,623) of the Head Start and non-Head Start children who were reported having mental health services received psychological testing (type of test administered unknown) but few were counseled or referred for further services.

- Nutritional services were again the least frequently provided. A greater number of children receiving these services were referred for additional assessment compared to other health services.

- Medicaid certification appeared to be unrelated to the receipt of health services, as the proportion of Head Start and non-Head Start Medicaid certified children was almost equal to those who were ineligible or of unknown status.

POLICY CONSIDERATIONS:

- The screening package mandated for Head Start children might be defined in greater detail (test specification, for instance) to assure measures of comparability among Head Start programs, as has been reflected on the 1975 revision of the Head Start performance standards.

Further studies regarding the quality of health services received could provide the basis for revising standards for health care.

- Additional program resources to Head Start projects would greatly enhance their capability in providing services to families of Head Start children. The parent involvement component could be particularly useful toward this end.

Issue Area 4: Extent to which the projects were able to provide/obtain direct EPSDT reimbursable services for eligible children.

FINDINGS:

- Only two Head Start projects obtained direct reimbursement by Medicaid EPSDT, either as vendor or through purchase of health service agreements.

PROBLEMS:

- There was only one contract reported between a public agency and a Head Start project. Relationships were generally quite informal, with minimal assistance or support provided by public agencies to Head Start projects. In fact, many projects reported resistance by public agencies, particularly at the local level, regarding Head Start roles in EPSDT delivery.
- Many projects relied on previous patterns of health service arrangements in the case of Head Start children, possibly minimizing the use of Medicaid.

POLICY CONSIDERATIONS:

- The EPSDT coordinator could be trained to have close familiarity with Head Start program objectives and health-related matters so that there can be full integration of the EPSDT effort into the overall Head Start program. The position will benefit in this regard, should it be made full-time and be placed under the supervision of the health services coordinator.
- OCD might encourage more reimbursement relationships through ensuring that the projects have available full information on the availability of EPSDT services in their areas.

Issue Area 5: Extent to which supportive services were provided to non-Head Start children.

FINDINGS:

- There were limitations on the level and adequacy of supportive services provided to non-Head Start children. The Head Start projects were the major providers of these services to non-Head Start children, suggesting a general understanding of intent of the EPSDT Collaborative Effort. The parent involvement component was the most effective tool in outreach to non-Head Start children.

PROBLEMS:

- Previous approaches to providing supportive services in the Head Start programs were generally maintained during the collaborative effort, limiting the provision of supportive services to non-Head Start population.
- Public agencies tended to focus their supportive services on follow-up rather than outreach, again limiting the number of non-Head Start children served. The voluntary sector proved to be of minimal help to the projects in delivering supportive services.
- The non-Head Start child was less likely to receive follow-up services, particularly verification, possibly related again to emphasis by the projects on previous patterns of supportive services delivery.
- Recordkeeping for non-Head Start children was considerably weaker than for Head Start children, possibly the result of a lack of resources in the projects.

POLICY CONSIDERATIONS:

- Better coordination between Head Start projects and public agencies would provide more consistent and expanded delivery of supportive services to non-Head Start children. The projects might also seek reimbursement for these services provided they are part of the state EPSDT plan.
- Head Start projects might be encouraged to utilize more fully whatever resources are available in the voluntary sector for delivery of supportive services, particularly in the areas of outreach.
- Head Start programs might be encouraged to use the parent involvement component to the fullest extent to ensure that all siblings of Head Start enrollees become participants in the EPSDT effort, thereby also expanding provision of supportive services. Likewise, door-to-door contact could be used more extensively as an outreach technique
- Requirement of recordkeeping on the provision of services to non-Head Start children by the projects would both maximize supportive service delivery and improve procedural quality in all aspects of the collaborative effort.

Issue Area 6: Comparison of Head Start Program Performance Standards and state EPSDT plans.

FINDINGS:

- The state plans' description of supportive services is particularly limited, and may not provide the same degree of delivery as Head Start potentially could.
- There is no uniformity regarding the types and quality of services provided among the various states.

PROBLEMS:

- With the exception of California, none of the states provide a mechanism for consumer participation in their EPSDT plans.
- Although most states cite the importance in their plans of coordination with existing health resources, none specify procedures for ensuring that linkage does occur.
- Lack of specificity and uniformity in regard to types and levels of service provided, complicates the collaborative process for an agency such as Head Start, and necessitates a state by state analysis of the health benefit package.
- In those states which provide reimbursement for the entire screening package, Head Start, even if it achieves vendor status, may not be able to receive reimbursement unless it delivers the entire package of screening services.

POLICY CONSIDERATIONS:

- Development of uniform national standards for EPSDT plans, by types and levels of services, and provision for reimbursement might expedite and facilitate the relationship between Head Start programs and EPSDT.

- Consideration might be given to developing reimbursement procedures in state plans which permit payment for provision of specific services rather than an entire package, since a provider might be encouraged through this arrangement to perform procedures which might otherwise have been neglected.

Issue Area 7: Analysis of State EPSDT plans and providers' performance.

FINDINGS:

- State Medicaid/EPSDT plans were characterized by their complexity, with disparate delegation of responsibilites to different public and private agencies at both the state and local levels.
- There was overall failure by the Head Start programs to be integrated into the delivery of Medicaid/EPSDT services at the state or local levels by achieving vendor status.
- The collaborative effort had minimal impact on the institutional arrangements of a state Medicaid/EPSDT plan or program.

PROBLEMS

- The format of many state plans is complex, and often the phrasing is ambiguous or obscure.
- Variations among state plans concerning their reimbursement policies can and do lead to alienation and frustration among vendors who apply for reimbursement for services not sanctioned by the plans.
- Providers often fail to offer areas of screening when these services are not explicitly permitted for reimbursement under the state plan.
- Restrictions in the plans on the awarding of vendor status to community agencies limits the availability of supportive service and the potential for Head Start and similar groups to become service vendors.

POLICY CONSIDERATIONS

- Clear and precise information on the operational and procedural aspects of state EPSDT plans might be provided to Head Start programs, as well as to other agencies and consumers, in order to increase the efficient use of these resources and services.
- More effective integration of Head Start and EPSDT services might be accomplished through review by SRS of Head Start's provision of the specific services rendered. Health liaison specialists may have an important role to play in this regard, through their active intercession between Head Start programs and local EPSDT/Medicaid agencies to promote closer and more efficient working relationships.

(For considerations on vendor and provider problems, see Issue Area 5, Policy Considerations.)

Issue Area 8: Cost utilization factors pertaining to service delivery.

FINDINGS:

- Although expenditures for Head Start/EPSDT varied from project to project, the average cost per child was assessed at $45.00.
- About 75% of the total EPSDT expenditure for all regions and IMPD programs originated from the Head Start/EPSDT supplemental grant. Contributions from other sources were minimal.
- Some programs extended beyond the supplemental grant to support the collaborative effort, suggesting that the grant, alone, was not sufficient to sustain the implementation of EPSDT/Head Start.
- Overall, 48% of all dollars expended for the EPSDT program were for direct health services, with 27% and 25% attributable to supportive costs and administrative costs, respectively.
- Most of the time (55%), payment for provision of EPSDT health services included Head Start funds, leading to the conclusion that Head Start provided the major financial support to the collaborative effort.

PROBLEMS:

- Lack of providers, failure to reimburse for certain services in accordance with a state EPSDT plan, and infrequent use of reimbursement for mental health and nutritional services may be contributing factors to the low percentage (6%) of Medicaid/EPSDT services.
- Some lack of discretion regarding administrative costs may have had an adverse impact on the level of services provided.

POLICY CONSIDERATIONS:

- Review could be undertaken by the projects to determine how monies directed toward meeting the objectives of the collaborative effort could be maximized, and how monies directed to lower priority areas within the effort could be minimized.
- Projects might begin to develop a system containing provisions for identifying reimbursement areas and requirements. Such a system may also improve managerial procedures for the projects and may clarify objectives and methods of attaining them.
- Because of the unreliability of cost/revenue data, more emphasis might be placed on the retrieval of this information during the second year evaluation.
- For the supplemental grant, monies might be more effectively distributed according to a formula that takes into account program size and other variables.
- Designation by the local/state Medicaid agency of the Head Start program as a provider of health services would ease reliance on the supplemental grant and would also faciliate service delivery (supportive and health related) to the target population.
- Where such designation is not possible, programs may be encouraged to reach agreements with local health providers that are recipients of third party payments, to share in any monies received as a result of services delivered to children referred by the projects.
- A sliding fee scale system might be implemented, selectively, to facilitate payment for direct services (to non-Medicaid eligible families only).

Issue Area 9: Technical assistance needs of the projects and staff characteristics.

Technical Assistance Needs

FINDINGS:

- Head Start projects had particular technical assistance needs in the areas of outreach and follow-up. For the former, there was a need to plan and develop a strategy with the state and local EPSDT agencies. For the latter, there was a need to plan and develop systems which effectively met this objective.
- To the degree that any source was helpful in providing technical aid, the health liaison specialist was most frequently cited. Overall, however, the projects reported minimal technical assistance provided.
- The most frequent type of technical assistance provided was in the form of workshop and information provision.

PROBLEMS:

- State Medicaid/EPSDT agencies were usually not a source of technical assistance to the projects as had been anticipated.
- The agent with the responsibility for negotiation with state/local Medicaid agencies for vendor recognition was not pinpointed by OCD or regional offices; nor was there any assistance provided in arranging fiscal affairs or administrative procedures.

POLICY CONSIDERATIONS:

- Administration and planning, as well as development of coordination and linkages between the projects and the Medicaid agencies, are potentially fruitful areas for concentration of technical assistance during the second year effort.
- The role of the health liaison specialist might be more clearly defined in regard to its ongoing technical assistance function and as a link between the projects and the Medicaid agencies.

Staff Characteristics

FINDINGS:

- A majority of the EPSDT coordinators were full-time personnel with some college background and several years of previous experience in Head Start.
- The organization of EPSDT, as an additional responsibility for the Head Start health service components, often placed severe strain on existing staff.

PROBLEMS:

- Training of health and other staff for the EPSDT effort was generally limited, and consisted primarily of OCD workshops.

POLICY CONSIDERATIONS:

- Training of the Head Start staff, particularly those members who have direct responsibility for the operation of the collaborative effort, is crucial.
- Head Start programs could be encouraged to recruit and hire persons with professional background in the EPSDT/Medicaid program, who would then be responsible for coordinating Head Start/EPSDT services. This position might best be utilized were it made full-time and placed under the supervision of the health services coordinator.

II. BACKGROUND OF EPSDT PROGRAM AND THE COLLABORATIVE EFFORT

A. LEGISLATIVE HISTORY OF EPSDT

The 1967 amendments to the Medicaid provisions, Title XIX, of the Social Security Act mandated a national program of preventive health services for low-income children ages 0-21 through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. These amendments were signed into law on January 2, 1968 to become effective July 1, 1969 and they represented a culmination of several years' activities on the part of HEW officials to broaden the coverage of health and medical care for poor children by establishing federal standards for coordination and provision of services. Because of the linkage to public assistance as a major criterion for eligibility, this new and extensive health program was integrated into the public welfare system which carries responsibility for other income maintenance and medical assistance programs, including Medicaid.

Until the passage of the 1967 legislation, federal financing for child health services had been provided primarily through Title V of the Social Security Act which had authorized screening services since 1935 through Maternity and Child Health (supervision of preventive services and well-baby clinics) and Crippled Children services (diagnosis and treatment). In the early 1960's, however, there was an expansion of health services for children at the federal level through the provision of Maternity and Infant Care (1963), Children and Youth projects (1965) and other infant care programs. Through the Economic Opportunity Act of 1964 also, efforts were made to provide health programs for low-income children (Head Start) and communities (neighborhood health clinics). However, each of these programs was unrelated, had different funding mechanisms; and more critically, each reached only small numbers of children.*

As an effort to bring about coordination of these various health services, federal provisions for EPSDT called for the Title XIX (Medicaid) agency in each state to enter into agreements with the Title V agency (Maternal and Child Health, usually the Health Department) so that such agencies might be a provider of services to be reimbursed through Title XIX. There was also expressed concern about linkages to other community resources.

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*In 1955, for instance, it was estimated that only 6.5% of the children under 21 in the U.S. were reached by Title V programs. Anne Marie Foltz, _Early Periodic Screening, Diagnosis and Treatment (EPSDT): The Development of Ambiguous Federal Policy_. Yale University School of Medicine, Health Policy Project, HEW Grant No. 5-RO1-HS-00900, June 1974.

There was an eighteen month delay, however, before regulations were promulgated by HEW for implementation of the EPSDT program. Various reasons have been cited for this delay, the most prominent being the resistance by the states to providing the extensive screening and subsequent diagnosis and treatment called for because of their cost implications.*

Regulations currently in effect were issued by the Social and Rehabilitation Services (SRS), the administering unit in HEW for EPSDT, in November 1971 to be effective February 1972. These extended the date for full implementation of the EPSDT program and allowed the states to initiate these services by apportioning the children to be served on the basis of age. The age group to be served first was to include children ages 0-6, with services gradually expanded to include all youth up to age 21 by July 1, 1973.

Because of increasing public concern about the delay in implementing EPSDT, Congress passed further amendments calling for penalties against any state (1% of the federal share of AFDC for each quarter of non-compliance) which did not provide for full implementation of the program by the specified time period

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*From Michael D. Edwards, "The Children Are Still Waiting," The Nation, September 28, 1974, and the Hearings of Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, Getting Ready for National Health Insurance: Shortchanging Children, October, 1975.

in the SRS regulation. (As of August 1974, eight states*
had had penalties levied against them.)

B. DESCRIPTION OF MEDICAID/EPSDT

Because EPSDT is an integral part of Medicaid, the rules and regulations that pertain to the administration of that medical assistance program are applicable to EPSDT as well. Medicaid can be described as a federal-state financed, state administered program with the federal contribution varying from 50% to 83% of cost, depending upon the provisions of an individual state plan. Medicaid (and EPSDT) is usually administered on the state level by the public welfare department under the single state agency rule of the Social Security provisions.

The characteristics of Medicaid vary greatly from state to state. The federal guidelines for the program are broad and general and only certain basic services are mandated. Thus, states have wide latitude in defining the scope and nature of the services to be provided within their area. Rather than being viewed as one uniform national program, Medicaid and EPSDT can best be described as programs which are administered on the basis of 49 separate state plans which resemble each other only in their basic minimum requirements. (The state of Arizona does not participate in the Medicaid program.)

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*Hawaii, Indiana, Minnesota, Montana, New Mexico, North Dakota, Pennsylvania, and California.

Individual state plans provide varying definitions for Medicaid and EPSDT services in several areas.

1. Eligibility level: All states must serve the categorically needy as defined by federal regulations but the state has the option of setting definitions for serving the medically indigent, i.e., those low-income families who are not public assistance recipients.

2. Provider status: The state can establish criteria for awarding vendor status to providers of medical services and thus restrict the category of persons or groups to be reimbursed for services rendered to the medically needy. In some states, only licensed private physicians are reimbursed; while in others, services rendered by neighborhood clinics or nurse clinicians are reimbursable also.*

3. Benefit structure: Beyond the minimum services required by regulation, the states have the option of determining additional benefits, if any, to be offered to Medicaid recipients. These benefits can be limited by

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*Potentially, the Health Liaison Specialist of the American Academy of Pediatrics could influence the selection of medical provider category.

utilization controls. For example, California Medicaid recipients are permitted two physician visits per month (except for EPSDT services).

4. Reimbursement rates: States determine the rate at which providers are reimbursed for services rendered. Reimbursement methods range from payment for "reasonable cost" to a flat rate for specific services which bears little relationship to the cost of providing the same service in the private sector.

5. Billing and collection procedures: Billing and collection procedures also vary from state to state and may affect the submission of bills and the frequency and rapidity of payment to providers. For instance, in many states, there is a lag of several months between the time a service is rendered and payment is received by the provider. This factor together with low reimbursement rates tend to reduce the number of providers participating in the Medicaid program.

C. IMPACT UPON THE DELIVERY OF EPSDT SERVICES

The problems that have been identified in the administration of Medicaid, both in the provision and definition of services as well as the overall management, have immediate impact upon the scope and nature of the EPSDT program and create barriers for its effective implementation.

Federal regulations for EPSDT designate the state Medicaid agency (public welfare unit) as responsible for providing or obtaining health services for EPSDT-eligible children. This responsibility includes such supportive services as outreach (locating and informing families with eligible children about the program) and recruitment of both consumers and providers of EPSDT services. In most instances, however, the emphasis in program implementation has primarily been upon screening, reflecting the major new service mandated through the authorization of the EPSDT program.

Then too, the availability of providers and community health resources is uneven around the U.S. Thus, the development of a linkage system whereby eligible children can be routinely referred for a whole range of EPSDT services has created a major problem for planning and administration. Moreover, state welfare agencies do not perceive that they have a primary role in the delivery of health services, since most find their time consumed in the administration of public assistance and social services. Therefore, they have placed relatively less priority upon developing and providing a comprehensive health care system.

Several questions can be posed regarding the viability of broad screening programs within the context of comprehensive health care. First of all, is the separation of screening from diagnosis and treatment services medically sound? Then, how often should screening be provided, and what kinds of supportive services are needed to assure comprehensive care?

Health professionals differ among themselves regarding the type of preventive services and screening techniques in relationship to diagnosis and treatment that should be universally available. Moreover, the frequency that such services should be provided is open to professional judgment. For instance, Dr. Frederick North, a pediatrician, stated before the House Subcommittee on EPSDT that "any separation of screening from the direct context of comprehensive care multiplies the costs and difficulties of providing preventive services and of insuring adequate diagnosis and treatment."*

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*Hearings Op. cit., p. 96.

He pointed out that there is a 30% loss between referral and appointments kept when screening is rendered separately from the other medical services. Others believe that screening is a convenient way of sorting out individuals who have some likelihood of pathology in a given area.*

Therefore, the problems of implementing EPSDT at the state and local level may reflect the lack of consensus -- public and professional -- regarding the construction of a health care system as well as certain inadequacies in that system as now operated throughout the U.S. The General Accounting Office, in its January 1975 report on EPSDT,** cited several factors impeding the program: inadequate outreach techniques, lack of utilization of allied health professionals, inadequate procedures for periodic updating of screenings and inadequate follow-up mechanisms, again reflecting the lack of comprehensive approaches to health care as well as a failure to fully adhere to federal standards.

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*Dr. Frederick Green, former Director, U.S. Children's Bureau, HEW/OCD. House Subcommittee Hearings, op. cit., p.8.

**Improvements Needed to Speed Implementation of Medicaid's Early and Periodic screening, Diagnosis and Treatment Program. Comptroller General of the United States, DHEW, Social and Rehabilitation Services, Washington, D.C., January 9, 1975.

Even if EPSDT were fully implemented, however, these services would only reach about one half of the nation's 25 million children in low-income families. (There are 13 million Medicaid eligible children nationally according to the House Subcommittee report.) Even most of the children eligible for EPSDT are beyond the reach of the health care system because of its emphasis upon crisis or emergency care.* Yet it is these children who have the highest incidence of correctible medical problems.** The basic challenge of EPSDT, therefore, is to trigger changes in health care delivery for children as a first step towad evolving a truly comprehensive health program.

D. PROFILE OF HEAD START

Head Start is a national demonstration program to provide comprehensive developmental services to low-income pre-school children, and in its ten years' existence it has become preeminently identified as an effective model for the delivery of integrated human services. Since its inception, Head Start program goals have stressed an interdisciplinary approach to child development in order to assure that the various services, staff functions and skills needed to enhance the social functioning of the child and his family might be available.

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*ABC News Closeup on Children: A Case of Neglect. Transcript of Broadcast over the ABC Television Network, July 17, 1974.

**Ibid.

Head Start was originally conceived in 1964 within the context of a community action strategy.* The intent at the time was to demonstrate the efficacy of intervention into the life of the "disadvantaged child" through a host of education, health and nutrition, and social services arrayed with the parent and community as partners in the service delivery process. Many of the early supporters of Head start raised public expectations about the possibility of long term cognitive gains in preschool children that could be translated into school success. Head Start, as a specific program strategy, however, clearly emphasized the necessity to deal with the whole child, i.e., his physical, mental, nutritional, social and emotional needs, in order to better prepare him to participate and achieve in regular school.

The Office of Child Development/HEW, now the administering unit for Head Start, has reinforced the program's priority goal of achieving social competency among low-income preschool children through the issuance of performance standards. These standards, revised as of 7/1/75, set forth the goals and objectives of four components -- Education, Social Services, Parent Involvement, and Health -- which must be part of each Head Start Program.**

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*Head Start was an integral part of the Economic Opportunity Act of 1964. Its most recent enabling legislation is the Head Start, Economic Opportunity and Community Partner Act of 1974.

**A full discussion of the Head Start Program Performance Standards is presented later in this report.

Head Start now provides services to 350,000 children nationally, 80% on a full-year basis, through an annual authorization of around $475 million.

Head Start has achieved notable success in meeting specific goals to improve the health and nutritional status of its enrollees. The New York Times, in an article dated 6/8/75, is laudatory in its praise of Head Start efforts to provide standardized health care to preschool children in low-income communities.* As of 1973, Head Start has also been viewed as an appropriate community service to recruit and provide services to handicapped children because of its intensive outreach and integrated services approach.

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* N.Y. Times, 6/8/75, "Head Start; Ten Years Old and Planning Experiments.

III. GENESIS OF THE COLLABORATION BETWEEN HEAD START AND MEDICAID EPSDT

In December 1973, the Office of Child Development (OCD) and the Medical Services Administration (MSA) [1] jointly announced a collaboration between the Head Start and EPSDT programs. The rationale for this move was recognition that:

- the goal and objectives of the health services components of Head Start and Medicaid/EPSDT are mutual, since both focus on prevention, identification and treatment of illness, and linkage of the child and family to an ongoing health system[2]

Both OCD and MSA serve primarily the same clientele--low-income families--and both agencies are concerned with continuity of care and health services integration. Thus, this common frame of reference could serve as a catalyst to generate a wide range of local collaboration and cooperation between the two programs that would help to strengthen Head Start health components and also assist state and local agencies in administering and implementing EPSDT programs.

The strategy of the collabrative effort was to utilize local Head Start programs as a mechanism for making EPSDT services available to Medicaid eligible children 0-6 years.

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[1] The division with the social and rehabilitation service unit directly responsible for Medicaid and EPSDT.

[2] Memorandum dated December 12, 1973 from Howard Newman Commissioner, Medical Service Administration and Saul Rosoff acting Director, Office of Child Development to the Social Rehabilitation Service.

The plan called for Head Start to refer potentially eligible children to Medicaid for certification. In turn, Medicaid would supply EPSDT services in accordance with the state Medicaid /EPSDT plan. Any additional health services for Head Start children not covered by the state Medicaid plan but required by the Head Start Performance Standards would be paid for by local Head Start programs. The Head Start projects approved for participation in the collaborative effort would assist the Medicaid/ EPSDT agency by providing health-related support services, including case findings, transportation, public information, referral and follow-up services.

The Head Start projects were also assured that eligible children would receive the EPSDT services to which they are entitled. In addition the collaboration effort called for projects to provide services to non-Head Start children, including siblings of Head Start enrollees and other potentially eligible children in the Head Start target area.

Technical assistance was to be provided as part of a national contract with the American Academy of Pediatrics (AAP) which would supply health liaison specialists. The specialists were to assist the local Head Start project in making collaborative arrangements with Medicaid agencies. They were to also provide orientation and training sessions for the Head Start health services coordinators and assist them in planning and implementing the demonstration program.

On December 18, 1973, the Office of Child Development issued specified guidelines for the collaboration effort. These include:

- The collaborative program to be established as a demonstration effort for one year, with the possibility of continuing a second year.
- Staff already employed by Head Start programs in local areas to perform the core activities of the demonstration effort.
- Supplemental grants to be made available to hire additional staff or increase working hours of staff already on board.
- The health services coordinators in the Head Start program to be responsible for implementing the collaboration as well as directing and coordinating all health services, such as:
  - informing families about EPSDT services
  - arranging for transportation
  - aiding families in establishing Medicaid eligibility
  - assisting in securing medical appointments
  - maintaining individual health records to assist in tracking the provision of care
  - arranging for follow-up and referral.
- The health services coordinator to serve as liaison to the child and family, the public welfare and health officials and local health providers.
- The Head Start programs selected for the demonstration to provide health-related support services for Head Start and non-Head Start children recruited for participation in the EPSDT Collaborative Effort.

The criteria used by OCD to select grantees for the collaborative effort included: willingness to participate in the collaboration; ability to implement health services for children; the state Medicaid agency support of the collaboration; the project's ability and willingness to enroll and serve all Medicaid eligible Head Start children. For those projects serving non-Head Start Medicaid eligible children, it would be necessary to identify a significant number of children in the target area who were age 0-6. Priority was to be given to programs able to enroll in Medicaid/EPSDT the maximum number of Head Start children who were not presently served by Medicaid. A second, but important, priority consideration was given to the ability to enroll in Medicaid/EPSDT substantial numbers of non-Head Start children who were not covered by Medicaid.

Study Methodology

In May 1974, the Office of Child Development announced its plans to provide for an evaluation of the Head Start/EPSDT Collaborative Effort. The purpose of the evaluation, according to OCD, was to assess the extent to which the collaborative effort had been successful in achieving its goals and objectives by documenting the outcomes of the demonstration program. Boone, Young & Associates, Inc., was awarded the contract for the study in June 1974.

The evaluation of the Head Start/EPSDT Collaborative Effort required:

1. the selection of projects for in-depth analysis
2. the development of a series of data collection instruments which constituted the required recordkeeping system
3. data collection on all site visits to the selected projects
4. data processing
5. data analysis.

The relationship between these elements is shown in Exhibit 1 and each is discussed below.

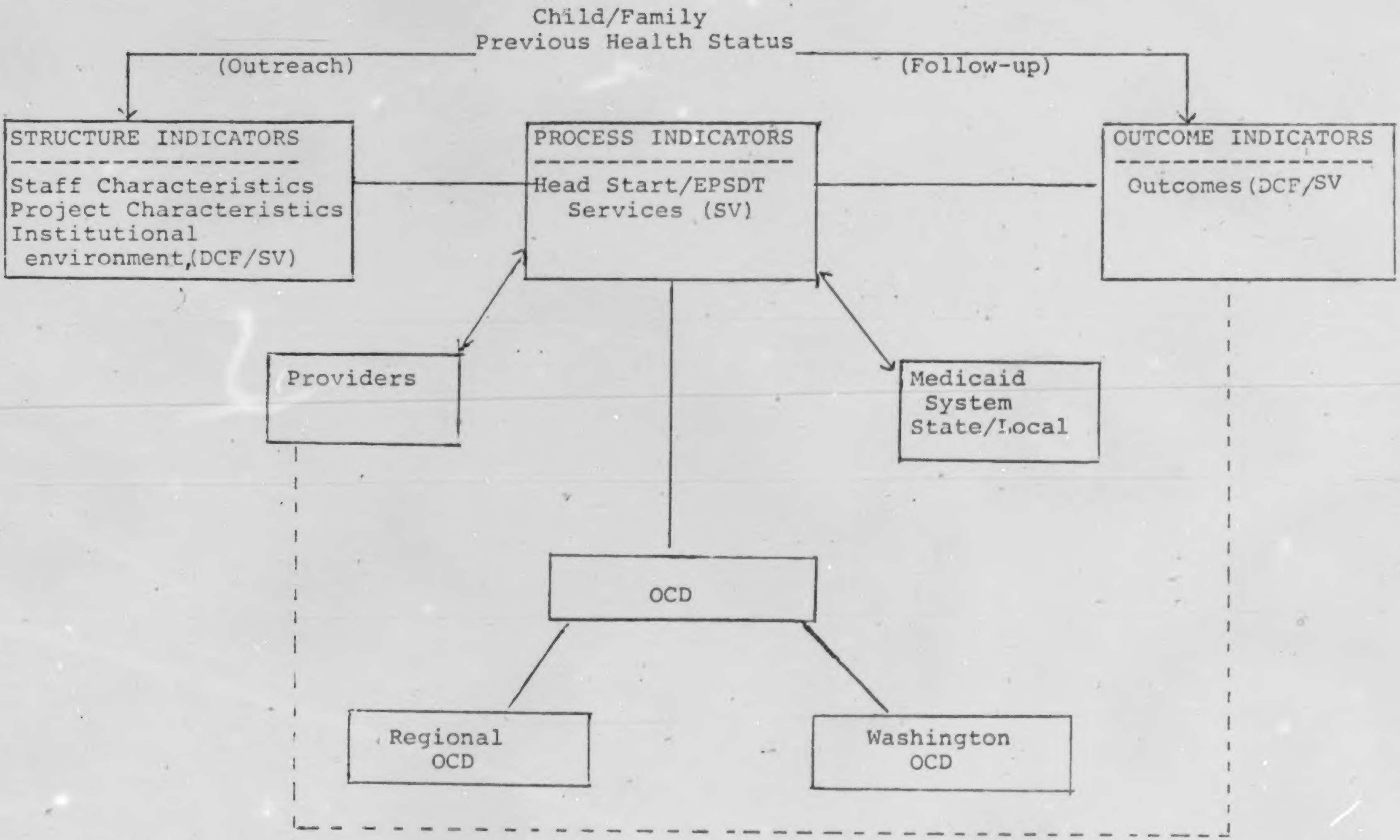
Project Selection

Thirty projects were selected from the universe of 198 demonstration sites funded for the Head Start/EPSDT Collaboration Effort for in-depth examination ad analysis. The sites were chosen within the twelve states designated as target states by the Office of Child Development for the evaluation. These states were: Massachusetts, New Jersey, Maryland, Mississippi, Tennessee, Illinois, Ohio, Texas, Missouri, Montana, California, and Oregon.

Head Start is a national program which allows for sufficient flexibility at the local level to be responsive to community needs. Medicaid/EPSDT programs also vary at the state and local level in regard to policy initiatives. Examination of the universe 198 projects revealed few similarities among the projects because of the highly diversified nature of these programs. It was therefore difficult

EXHIBIT I

EVALUATION INDICATORS FOR HEAD START/EPSDT COLLABORATIVE EFFORT


Child/Family
Previous Health Status
(Outreach)
(Follow-up)
STRUCTURE INDICATORS
Staff Characteristics
Project Characteristics
Institutional environment (DCF/SV)
PROCESS INDICATORS
Head Start/EPSDT Services (SV)
OUTCOME INDICATORS
Outcomes (DCF/SV
Providers
Medicaid System State/Local
OCD
Regional OCD
Washington OCD

Parenthesis indicate sources of information by methodology component:
DCF: Data collection forms
SV: site visits to selected projects
Data processing is not shown but is applied to develop previous status and outcome indicators

to find a basis of comparison upon which to draw a representative sample. In addition to the highly individualized nature of the projects, the selection process was complicated by other factors, including:

- the lack of baseline data on the funded projects
- the lack of uniformity and completeness of the available data presented in the grant proposals
- the inability to make contact with local projects to verify and collect baseline data because of time constraints
- the necessity of drawing a sample within the characteristics presented by funded projects.

Therefore, it was decided in discussion with OCD that the priority for selection of the 30 projects would be based upon an identification of the various network of barriers, both internal and external, which the local project faced that might impact upon the outcome of the collaborative effort. Efforts were directed at examining programmatic problems and possible solutions to determine what could realistically be expected of the local projects.[3] Options for possible solutions to the problems were also considered.

The following criteria were agreed upon as the basis for selection of the thirty projects:

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[3] Descriptive information is provided in Appendix ____ on the Indian and migrant workers projects selected for in-depth study.

- identification of institutional barriers to the implementation of EPSDT
- programmatic aspects of delivery of health care to children
- rural/urban characteristics
- program size
- program sponsorship
- geographic dispersion within the state.

The funded projects exhibit a strong rural bias. For example, in states that have densely populated areas, such as New York and California, only a relatively small number of rural programs were funded. Head Start, in general, has a strong urban focus, and large numbers of Medicaid eligible children are generally found in densely populated communities. This selection attempted to compensate for the rural bias by including several large urban areas. With the exception of Paterson, New Jersey and Baltimore, Maryland, the only areas which presented us with the opportunity to study urban areas were in Region 5. This explains the slightly higher concentration of selected projects in this region.

A profile of the projects selected for an in-depth analysis can be found in the interim report. Exhibit II provides additional information.

EXHIBIT II

CHARACTERISTICS OF SELECTED PROJECTS

TARGET STATES AND SELECTED PROJECTS	RURAL/ URBAN	RANGE OF PROGRAM SIZE WITHIN STATE	NO. OF CHILDREN		PROBLEMS AND INSTITUTIONAL CHARACTERISTICS							
			FUNDING LEVEL	PLAN TO SERVE	Provider Problems	Client Education	Transportation	Welfare Agency Problems	Problems With ID of Eligibles	Lack of Preventive Health Services	Insufficient Health Resources	Lack of Follow-up
MASSACHUSETTS (I) Leominster	R	60-405	210	50	X		X					
Worcester	U	60-405	405	650						X		X
NEW JERSEY (II) Toms River	R	120-440	150	200	X		X				X	
Paterson	U	120-440	180	4750	X					X	X	X
Trenton	U	120-440	290	200	X		X					
MARYLAND (III) Baltimore	U	60-463	463	150		X	X					
Centerville	R	60-463	152	150	X	X						X
MISSISSIPPI (IV) Bolivar	R	140-2745	2508	250	X		X	X				
Tougaloo	R	140-2745	1428	1169		X					X	
TENNESSEE (IV) Kingston	M	140-580	140	488			X					
ILLINOIS (V) Cook County	U	240-7276	1080	5000						X	X	X
East St. Louis	U	240-7276	390	689		X						
Danville	R	240-7276	260	92	X		X					
OHIO (V) Cincinnati	U	135-1158	985	2000		X	X				X	
Dayton	M	135-1158	360	--								

Code:

R = Rural U = Urban M = Mixed

EXHIBIT II
(Cont'd.)

CHARACTERISTICS OF SELECTED PROJECTS

TARGET STATES AND SELECTED PROJECTS	RURAL/ URBAN	RANGE OF PROGRAM SIZE WITHIN STATE	NO. OF CHILDREN		PROBLEMS AND INSTITUTIONAL CHARACTERISTICS							
			FUNDING LEVEL	PLAN TO SERVE	Provider Problems	Client Education	Transportation	Welfare Agency Problems	Problems With ID of Eligibles	Preventive Health Services	Insufficient Health Resources	Lack of Follow-up
OHIO (Cont'd.)												
Sandusky	M	135-1158	120	250		X		X		X	X	
TEXAS (VI)												
Amarillo	M	123-277	720	400		X						
Lubbock	U	123-277	260	10								
Houston	M		1650	--				X			X	
Laredo	R	123-277	1277	351	X				X			
MISSOURI (VII)												
Appleton	R	120-2240	120	600	X							
Springfield	M	120-2240	440	as many as possible	X							
MONTANA (VIII)												
Billings	U	120-180	120	266		X	X	X			X	
Blackfeet Tribe	R	120-180	120	100	X							
Fort Peck	R	120-180	180	182		X						
CALIFORNIA (IX)												
Bakersfield	R	35-353	66-100	267	X						X	
El Centro	R	35-353	300	300	X						X	
Fresno	R	35-353	120	400	X							
OREGON (X)												
Eugene	M	45-430	120	all within community	X							
Medford	R	45-430	150	--	X		X					

Code:

R = Rural U = Urban M = Mixed

Data Collection Instruments and Recordkeeping System

A set of data collection forms was designed for the study to serve two purposes: 1) to obtain information necessary to the evaluation; 2) to support local projects' recordkeeping activities, particularly as related to the health component and the collaboration between Head Start and state and local agencies administering EPSDT. Copies of the forms and the associated instructions were provided in Appendix C of the interim report.

The data collection instruments for the study were:

- Health Care Intake Form: a form to be used by each funded project and completed once for each child participating in the Head Start EPSDT Collaboration Effort, at the time he is first recruited for EPSDT services. It is designed to collect information regarding:
  - the child's Medicaid status
  - the child's status with regard to Head Start
  - the child's previous health record for the twelve months prior to the collaboration
- Health Care Encounter Form: to be completed monthly for each child in the 30 selected projects only. it is designed to collect data cumulatively by child on the following elements of health care service provided:
  - the type of visit (screening, diagnostic, counseling referral, or treatment)
  - the disposition of the case (including follow-up visits where indicated)
  - the assessed value of the provided services.

- Health Care Composite Visit Form: to be completed monthly by project for the remaining 170 projects. It records information separately for Head Start and non-Head Start children regarding:
  - the total number of visits by type (screening, diagnostic, counselling/referral, or treatment) of children in the project during that month
  - the disposition of cases (the number of referrals, follow-ups, and completed cases).
- End of the Year Status Report: designed to be completed cumulatively by project at the end of the year. Collects information regarding:
  - the participating children's Medicaid status
  - the amount of turnover the project experienced
  - the disposition of medical records.
- Staff Profile Form: designed to record information regarding staffing patterns for the Head Start/EPSDT Collaboration Effort. Collects information regarding the staff's:
  - employment status
  - duties and responsibilities
  - educational background
  - previous employment/experience.
- Time Utilization Form: designed to assess the quarterly distribution of the Head Start/EPSDT staff time to the following categories:
  - direct labor
  - supportive labor
  - administrative labor.

- Income Sources Form: designed to be completed once during the program year to identify the extent to which the Head Start program is making use of available resources.
- Expenditure Form: designed to be completed once a year to collect information on how available resources are used to fulfill the requirements of the Head Start/EPSDT Collaboration Effort.
- Medicaid Profile Form: designed to be completed by the Health Liaison Specialist. Collects background information on the Head Start projects regarding its status and its understanding of EPSDT Medicaid.

Site Visits

One to two-day site visits were made to 24 selected projects. The purpose of the site visits was to obtain information concerning selected issues surrounding the implementation of the Head Start/EPSDT Collaborative Effort; for example, start-up activity, relationships and agreements with state/local Medicaid agencies, provider arrangements, etc. The interviewer attempted to assess the projects' understanding of the collaborative effort and to identify barriers which might affect the success or failure of efforts (i.e., arrangements with health providers, general lack of health provider, etc.). In addition, the site visits were used to check the validity and the reliability of the information reported by the projects via the data collection instruments.

The field staff received excellent cooperation at the local level. In all cases, the Head Start personnel were cooperative and informative. Medicaid personnel were generally responsive, as were health providers.

Data Processing

The objective of the data-processing effort has been to provide comprehensive and accurate summary data for the analysis. Procedures were developed for the processing of enrollment, Medicaid and previous care status data from the Intake Forms, the processing of EPSDT health services data from the Encounter, and the Composite forms, which are the basis for much of the first report.

There were four distinct phases involved in the processing of this data:

Phase I - Prepare Data

Phase II - Clean Data and Create Permanent Disk files

Phase III - Write, Debug, and Test Summary Programs

Phase IV - Run Data for Reports.

Pertinent aspects of each phase follow:

Phase I - Data Preparation

As the first step in processing the data forms, checks and corrections were made by hand as a preliminary to automated preparation steps. These manual steps included checks of program ID numbers, and logical completion of significant items.

The program for transferring data from card to disk, as well as the program to produce the formatted dump, had been written, tested and debugged prior to the implementation of Phase I. An instruction manual was developed for handling problems, e.g., treatment of non-responses.

The checked and corrected forms were then sent to the subcontractor, where they were double punched and verified. A temporary file was created on disk, and a formatted dump returned to Boone, Young & Associates.

Phase II Creation of Permanent Intake Files

The formatted dump created from the temporary file in Phase I was carefully checked by the Boone, Young & Associates staff for inconsistencies. Specific variables were selected in each type of file; for example, in the intake file we used status with regard to Head Start.

- Status with regard to Head Start (Pos 18 on disk or output field 0 4) should be equal to the number of participants who received/did not receive previous screening (Pos 22 on disk or Output Field 0 8).

- If the totals of these two fields are not equal an appropriate number of zeroes (no response) must be identified to account for the differences. A visual check of the column 0 4 or 0 8 is to be made to identify these non-responses. If totals for these fields are still not equal then a check for incorrect codes is to be made (0 4 or 0 8 ≠ 0, 1 or 2).

When incorrect codes were identified, the Head Start site was contacted and the correct responses ascertained. At this point, Boone, Young & Associates' staff completed a new form, coding ID number and corrected information only. These forms were then sent to the subcontractor where the data were keypunched and verified and overlayed on the old fields with the new correct data.

Once Boone, Young & Associates was satisfied that all corrections had been made for a batch, the subcontractor was instructed to update the Permanent Master File with the new batch.

A print-out of the updated master was sent to Boone, Young & Associates, where the new total was compared to a manual tape count (see Exhibit III).

Phase III - Write, Debug and Test Programs

Boone, Young & Associates worked with an independent consultant to develop the program. All programs were written in RPG II and were run on an IBM S/3 model 10 or 15. See appendix for detailed system and program description.

Phase IV - Run Actual Data for Final Report

This final phase produced the print-out of the information used in the analysis. The print-out was examined against several consistency checks. A sample print-out is included as Exhibit IV. The entry codes for transferring these and other data, e.g., those from the End-of-the-Year reports, to the tables are outlined in Appendix

DATA PROCESSING SYSTEM FLOW CHART

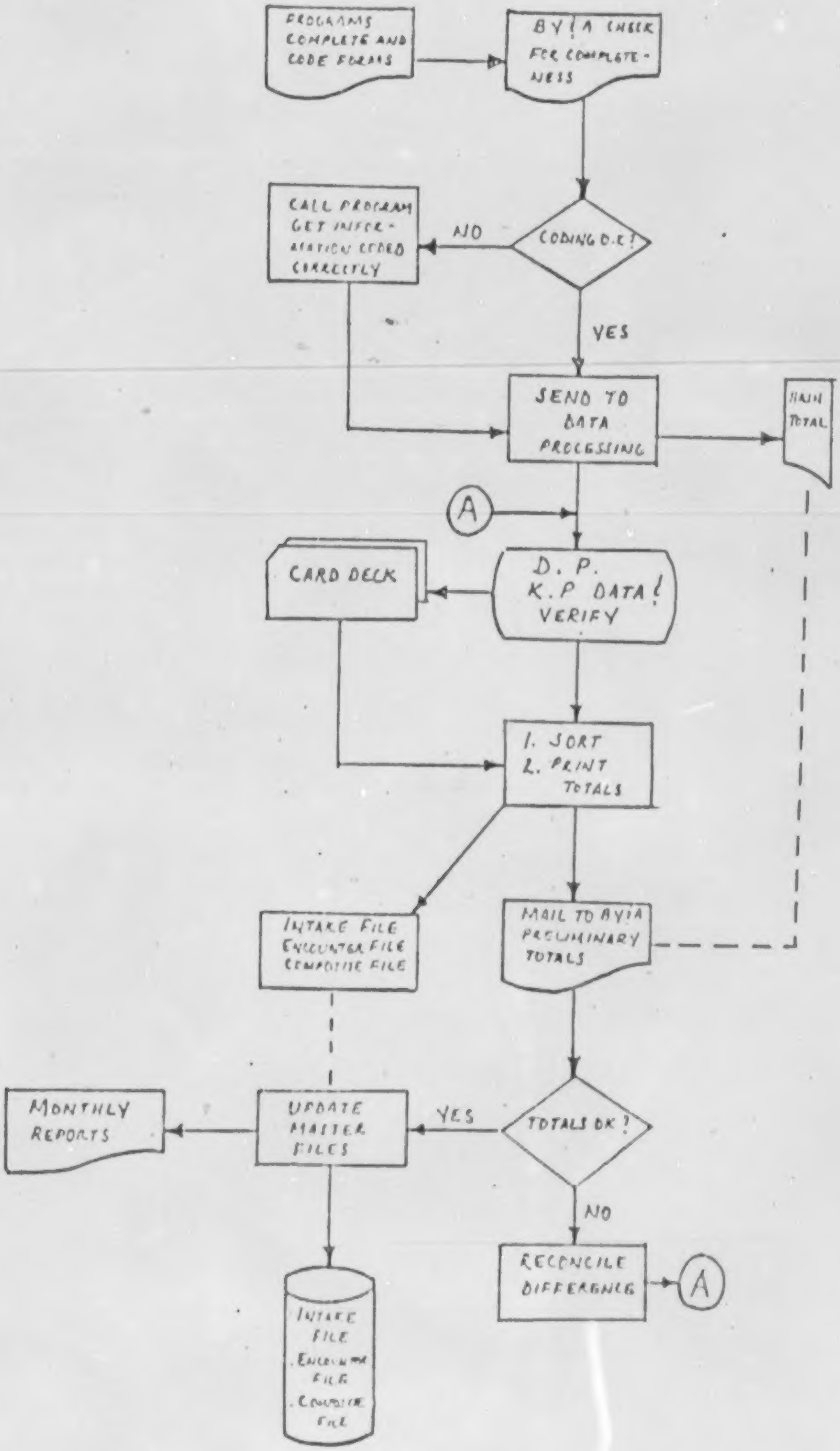
PROGRAMS COMPLETE AND CODE FORMS
BY!A CHECK FOR COMPLETENESS
CODING O.K!
NO
CALL PROGRAM GET INFORMATION CODED CORRECTLY
YES
SEND TO DATA PROCESSING
HASH TOTAL
A
CARD DECK
D. P. K.P DATA! VERIFY
1. SORT
2. PRINT TOTALS
INTAKE FILE
ENCOUNTER FILE
COMPOSITE FILE
MAIL TO BY!A PRELIMINARY TOTALS
TOTALS OK?
YES
NO
MONTHLY REPORTS
UPDATE MASTER FILES
RECONCILE DIFFERENCE
A
INTAKE FILE
.ENCOUNTER FILE
.COMPOSITE FILE

EXHIBIT IV

SAMPLE PAGE OF COMPUTER PRINT-OUT FOR ANALYSIS

```
                   TABLE  1   SECTION  E         TABLE  2   SECTION  8         TABLE  3   SECTION  E         TABLE  3   SECTION  E

                   01       02       03          01       02       03          01       02       03                   02       0

01-004-00          15       13        2          11        9        2           4        0        4          10        8       2
01-007-00         402      389       13         285      272       12         116       12      104         279      255      12
05-034-00         121      121        0          88       85        0          32       16       16          98       88
05-035-00         334      182      152         330      179      151           2        0        2         322      179      14
05-033-00         257      174       83         202      133       69          36        2       34         199      132      67
[illegible]       538      450       88         400      316       84         126        8      118         397      315      8
[illegible]         0        0        0           0        0        0           0        0        0           0        0
[illegible]       225      161       64         107       43       64         118        4      114         105       41      6
[illegible]       648      645        3         396      393        3         243        6      237         392      389       3
[illegible]       435      285      150         393      261      132          23       13       10         295      203      92
[illegible]       291      291        0         176      176        0         105        8       97         172      172
[illegible]       471      455       16         295      287        8         166      155       11         293      285
22-120-00         233      231        2          45       44        1         187       14      173          45       44
27-124-00         731      685       45         148      110       38         575        0      575          98       60      3
[illegible]       124      119        5         124      119        5           0        0        0         124      119       5
[illegible]         0        0        0           0        0        0           0        0        0           0        0
[illegible]       190      160       30         115       98       17          62        0       62         115       98      1
[illegible]       157      109       50          66       42       23          67       49       18          47       27      1
[illegible]       177      132       45         113       87       31          45        8       37         117       86      3
[illegible]       217      116      101         194       97       97          24        5       19         190       90      9
[illegible]       211      129       82          78       50       28          79       58       21          61       36      2
[illegible]        79       79        0          24       24        0          54        6       48          24       24
[illegible]       173      173        0          89       89        0          84       22       62          88       88
[illegible]      1092      946      146         203       97      104         836      668      168          74       65       9
[illegible]      3183     2229      954        2247     1572      669         637       36      601        2114     1465      52
[illegible]      5777     4029     1748        4305     2913     1392        1072      250      822        4053     2759     12
[illegible]      3026     2625      401        1572     1194      378        1413      165     1248        1546     1175     37
[illegible]      9891     8385     1506        4036     2938     1098        5916      716     5200        3646     2569    1065
[illegible]      8007     6852     1155        5473     4399     1074        2399      461     1938        5086     4065    1012
[illegible]     13004    11778  [illegible]    4247     3507      740        8441     2532     5909        3604     2992     50
[illegible]      4357     4189      168        2199     2057      142        2113     1052     1061        2048     1909     13
[illegible]      3253     2833      425        1574     1233      337        1390      210     1180        1510     1179     327
[illegible]       841      597      244         468      333      134         261      117      144         405      290     114
[illegible]      1903     1374      529        1245      812      428         556       68      488        1227      801     42
[illegible]      3328     2971      357        1187      983      201        1954      997      957         936      843     9
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Data Analysis

Through the course of the evaluation study, attempts were made to collect copies of the EPSDT plan of the target states. For this report, content analysis was performed on the available materials pertaining to the EPSDT plans and the Head Start performance standards in accordance with the issue areas for the study.

As the data collection forms were submitted by the projects, Boone, Young & Associates staff reveiwed the data for gross errors and prepared them for data processing. Phone calls were made to the projects to verify or correct incomplete or inaccurate information. Particular attention was paid to the coding of responses related to status with regard to Head Start, Medicaid eligibility, and previous health care. Additional cleaning/editing functions were performed through data processing. The rate of return for each of the data instruments is included in Appendix B.

Descriptive statistics, primarily frequency distributions, were used to analyze data collected. These have been presented in tabular form with narrative discussion to describe the observed relationships.

IV. ORGANIZATION AND OPERATION OF EPSDT

Introduction

The Head Start/EPSDT Collaborative Effort was designed to show replicable models of coordinating Head Start and EPSDT services to increase the number of low-income pre-school children receiving EPSDT. The guidelines for the demonstration programs required necessary modifications in organization and operation of the Head Start projects, such as an expanded role for the health services coordinator and provisions for EPSDT related public information, transportation, and recordkeeping. Modifications in programs were made, however, within the projects' understanding of these guidelines, their status prior to EPSDT, their relations with state and local agencies, and other factors.

Information was gathered to describe the ways in which the collaborative effort was organized and operated by the demonstration projects during the first year. The selected projects provided the basis for the detailed information on management and staffing, organization and planning, supportive services and health service arrangements, the operations and the results of outreach, follow-up and recordkeeping.

OCD guidelines for the Head Start/EPSDT Collaborative Effort required that the health services coordinator in the individual Head Start project be responsible for the administration and coordination of the EPSDT Collaborative Effort, and most of the projects complied with this mandate. Of the 25 selected projects analyzed, 16 had the health services coordinators responsible for design, operation and administration of the demonstration activities. In seven projects, responsibility was shared between the Head Start directors and the coordinators. Directors focused on design, overall administration and coordination in these instances, and the coordinators on operations and administrative details. One Head Start director had total management responsibility as did one social services director. The primary factor in these instances was the director's assessment of the importance of the collaborative effort and of the respective capabilities of staff.

A. EPSDT COORDINATORS: EDUCATION AND EMPLOYMENT STATUS

1. Analysis of Findings

National

Of the 198 projects that received a supplemental grant, 133 provided information on the background of the EPSDT coordinator. All projects reporting indicated that their EPSDT coordinator had at least a high school education. In addition, in 9 projects, the coordinator had attended college (area of specialty unknown) and 11 projects had a coordinator who had attended graduate school.

EPSDT coordinators in 79 of the demonstration Head Start/EPSDT collaboration projects were credentialed, either as a registered nurse (56) or a licensed practical nurse (23). With respect to employment status of the EPSDT coordinators, 110 out of 133 projects indicated that their EPSDT coordinators were employed full-time.

Selected Projects

In 24 out of the 25 selected projects reporting, the EPSDT coordinators had at least a high school education. Sixteen EPSDT coordinators in these projects had attended college, seven were college graduates, and one had attended graduate school. In 11 selected projects, the EPSDT coordinator was a registered nurse and, in two projects, this position was held by a licensed practical nurse. Staff paid with EPSDT funds were full-time in 20 out of 24 projects.

A majority of the selected projects, 16 out of 24, used their supplemental grants to employ full-time EPSDT coordinators. Exceptions to this pattern included one project, Cleveland, Mississippi, which employed two full-time coordinators, and one project in which only a part-time staff person was paid with EPSDT funds. In addition, 10 projects used their grant to employ other staff on a full-time basis. For example, three out of four projects in this group employed full-time nurses and seven out of 10 hired full-time health/EPSDT aides. In other instances, nursing and paraprofessional staff who were paid with supplemental grant funds were part-time. The Worcester, Mass., project used the EPSDT grant to maintain staff, including social service workers during the summer months to assist in outreach and recruitment.

It should be noted that other Head Start staff, whose salaries were not paid in full or in part by the EPSDT grant, were often involved in the collaborative effort. The on-site visits indicated that center directors and family service staff were in many instances continually engaged in various activities essential to the collaborative effort, e.g., negotiating for EPSDT services to be available to their project or recruiting through the Parent Involvement Component.

Center health staff had received special EPSDT training in 88% of the selected projects and only 76% of other staff had received training, usually through the efforts of the EPSDT coordinator, and was limited in amount. In those projects where the health staff had received special EPSDT training, it consisted only of OCD workshops and of possibly one state or local training session (limited); in eight cases, it involved additional sessions under various auspices (moderate); in two cases, it consisted of a large number of training opportunities (considerable). In three projects, no staff member--health or other--, had received special EPSDT training. There was some variation among selected projects regarding the proportion of health staff as compared to other staff who received special EPSDT training.

2. Conclusions on EPSDT Coordinators: Education and Employment Status

a. All the selected projects had designated as EPSDT coordinator a person who had at least high school training. Relatively fewer projects in the EPSDT effort involved EPSDT coordinators who had attended college and graduate school.

b. The majority of EPSDT coordinators had previous experience in Head Start and, since many of the projects reported that their EPSDT coordinator was full-time, the supplemental grant may have been used in many instances to augment the salaries of existing staff.

c. Because of the limitations of the supplemental grant and the need for additional staff resources to implement the demonstration program, some projects had to utilize non-EPSDT paid Head Start personnel to carry out certain functions.

d. Training of health and other staff for the EPSDT effort was generally limited and consisted primarily of OCD workshops.

3. Policy Considerations on EPSDT Coordinators: Education and Employment Status

a. Training of the Head Start staff, particularly those members who have direct responsibility for the operation of the EPSDT collaborative effort, is crucial, in order that the demonstration objectives are understood and clarified.

b. Such training might place specific emphasis upon ways in which all Head Start staff can support the collaborative effort as they perform their regular duties.

c. Familiarity with Head Start program objectives and health-related matters should enhance the capability of the EPSDT coordinator to provide an effective leadership and training role in implementing the EPSDT demonstration effort. Therefore, Head Start programs might be encouraged to recruit and hire persons with this specific background to be responsible for coordinating these services. Moreover, this position should be full-time and under the supervision of the health services coordinator to insure full integration of the EPSDT effort into the overall Head Start health program.

B. EPSDT COORDINATOR: AWARENESS OF EPSDT

1. Analysis of Findings

Coordinators and other involved staff in the 25 selected projects had varying degrees of awareness, or basic knowledge about EPSDT and its provisions. In most of the selected projects (22), the coordinators knew of the existence of the State EPSDT Plan. However, of this group, only 15 had a copy of the State Plan. In one project, this copy was determined to be out of date. Two coordinators indicated that they had descriptive materials on the state EPSDT program but they were uncertain whether these materials actually constituted the State Plan.

Whether the selected project staff had a copy of the State Plan or not, they tended to have little knowledge about the more technical aspects of the EPSDT program. For instance, in 19 out of 25 projects, staff knew the eligibility requirements for children and families to participate in the EPSDT program, but only 13 knew the step-by-step certification procedures. Staff in 15 projects were aware of the rates for reimburseable EPSDT services, but this may have been a result of activities associated with obtaining specific EPSDT services, including feedback from providers. A large majority of staff (in 23 of the 25 selected projects) relied upon their own initiative to obtain information about the state EPSDT program. Nineteen coordinators did state, however, that they had also learned of the program through the OCD Regional Training Workshops. In addition, 14 projects cited the health liaison specialist as another source of basic knowledge about the state EPSDT program.

Less than 50% of the projects indicated that the state or local Medicaid/EPSDT agency or providers of service were sources of basic information about the program. Of particular importance was the finding that the state rather than the local Medicaid/EPSDT agency proved to be a greater source of information (14 out of 25 projects reporting a state agency as a source, compared to 8 out of 25 reporting a local agency as a source). This may have been attributed to the state agency being the unit most responsible for the preparation and dissemination of information about the availability of the EPSDT program.

2. Conclusion on EPSDT Coordinator: Awareness of EPSDT Plans

- Being unfamiliar with new EPSDT programs, Head Start program staff had to rely, to a great degree, upon their own resources to obtain information about the state EPSDT services. Governmental agencies proved to be less reliable in this regard. On the other hand, knowledge about the EPSDT program among Head Start personnel tended to be general rather than specific, thereby limiting their ability to effect changes in the institutional arrangements of the program.

C. PLANNING FOR COLLABORATIVE EFFORT

1. Analysis of Findings

A majority of the projects--14--considered their supplementary grant proposals to be their EPSDT service plans. Only two projects developed more detailed plans. OCD had required submission of a questionnaire and workbook proposal by all potential grantees. These provided background data on the projects as well as an outline of how the demonstration collaborative effort would be organized and operated.

Elements described included:

- proposed management and organization
- potential and planned numbers of Head Start and non-Head Start children to be served in terms of children eligible and certified for Medicaid
- need in terms of gaps and problems with existing health service delivery systems
- arrangements for involving or relating to health service agencies, providers, and other important resources such as welfare, children's services, etc.
- proposed budget.

Even where projects considered the questionnaire and workbook to constitute a service plan, they often did not feel bound by their proposed service goals or approaches, particularly with respect to non-Head Start children. Various factors underlay this attitude including:

- subsequent confusion as to the necessity and desirability of serving non-Head Start children
- supplemental grants substantially less than requested
- unrealistic estimates of the time and effort required to establish relationships with other resources
- imposition of additional administrative requirements by OCD, i.e., the evaluation and completion of the associated forms.

2. Conclusions on Planning for Collaborative Effort

a. Many projects that had been selected for the EPSDT demonstration effort had initiated little planning for implementing the program.

b. Lack of clarity about demonstration objectives, and insufficient staff time augmented by relatively low supplemental grants to hire personnel, served to create a climate of confusion and resistance in the projects which hampered their ability to plan effectively.

c. Many projects were unaware of the administrative detail, including the imposition of evaluative procedures, and these additional duties may have overburdened already limited staff resources.

3. Policy Considerations on Planning for Collaborative Effort

a. OCD could initiate a systematic and detailed planning process for the implementation of the EPSDT collaborative effort. Such planning might include clarification of objectives, techniques for needs assessment, and surveys of community resources. Also, OCD might insure that the demonstration projects have, in hand, information about the provision and availability of EPSDT services in their area.

b. Head Start projects could be assisted in developing skills that will enhance their ability to make greater use of their existing staff by employing time utilization and manpower development procedures.

D. PROVISIONS FOR SUPPORTIVE SERVICES

1. Analysis of Findings

Both the Medicaid and Head Start programs were obligated to provide supportive services for non-Head Start children under the collaborative effort. Information regarding supportive services for Head Start were not collected as part of the study because:

- Head Start provided such services before the initiation of the collaborative effort
- already existing provisions for supportive services--overwhelmingly based on direct provisions--were not altered under the collaborative effort.

The Head Start projects were the major providers of supportive services for non-Head Start children. Twenty-one out of the 25 selected projects reported that they provided a variety of supportive services to this group and in eight instances Head Start was the sole provider of supportive services. The supportive services most usually provided by the Head Start project included publicity, tracking and verification. The provision of certification and recordkeeping/record disposition was the second most frequently reported service provided by Head Start.

In some instances where joint efforts were reported, the Head Start projects concentrated their supportive services on the siblings of Head Start enrollees or non-Medicaid certified children, while the public agency focused upon the Medicaid eligible population which tended to be Head Start children. In other instances, the Head Start project performed some aspect of tracking not done by the public agency.

The supportive services provided by public agencies were primarily in the area of follow-up, although only in a significant minority of cases, i.e., 20% across the three follow-up services--tracking, verification, recordkeeping/record disposition. This would suggest that the public agency as a rule was less concerned with recruiting new participants into the EPSDT program than they were in following up on those children already enrolled.

There was minimal involvement of voluntary agencies either as sole providers or in concert with other agencies, such as Head Start. A voluntary agency provided babysitting services in one case. Some voluntary agencies cooperated with Head Start in providing publicity and transportation. The relatively low level of involvement of the voluntary sector is probably attributable to:

- perceived level of program agency effort required for solicitation of voluntary agency
- lack of voluntary agency resources and/or knowledge to support involvement.

The least frequently provided supportive service to non-Head Start Children was babysitting. Undoubtedly this is a reflection of the lack of available resources, i.e., additional funds.

2. Conclusions on Supportive Services

a. The Head Start projects were the major provider of supportive services to non-Head Start children which suggests that there was a general appreciation of the requirement and intent of the EPSDT collaborative effort.

b. Public agencies tended to focus their supportive services on follow-up rather than outreach activities. The voluntary sector proved to be of little resource to the Head Start projects in providing supportive services.

3. Policy Considerations on Supportive Services

a. Specific attention might be given to developing ways in which Head Start and public agencies can work jointly in providing supportive services to non-Head Start children so that their efforts are better coordinated.

b. The Head Start programs could pursue arrangements for reimbursement as a new resource of those supportive services, provided they are part of the State EPSDT Plan.

c. Head Start programs could utilize resources that may be available in the voluntary sector, particularly in the area of outreach.

d. Comprehensive health services for low-income preschool children could include provision for babysitting services to insure that families will take advantage of the program.

E. ARRANGEMENTS FOR PROVISION OF HEALTH SERVICES

1. Analysis of Findings

One objective of the Head Start/EPSDT Collaborative Effort was to supplant Head Start provision of health services which Head Start provides either directly or through reimbursed or contributing health practitioners. The goal was to make greater use of Medicaid reimbursement to practitioners or directly to Head Start by treating the program as vendor.

Head Start projects served as providers across all screening categories as well as for dental, mental health, and nutritional treatment services for Head Start children,and to a somewhat lesser extent for non-Head Start children, i.e., not at all in the case of dental screening or dental and mental health treatment and with less frequency in other categories.

Head Start as the sole provider was the most predominant arrangement in the case of nutritional screening for Head Start children (nine out of 25 projects, with vendors being the second most prevalent in seven projects). Head Start was the second most prevalent provider for nutritional services. This arrangement also prevailed in the case of non-Head Start children, although the frequency was not as great.

2. Conclusions on Arrangements for Provision of Health Services

a. Various factors underlie the pattern of Head Start as provider, including the lack of alternative community resources and the difficulties entailed in obtaining the cooperation of private practitioners. This situation confronts projects particularly in areas where there are minimal health services. The resistance of general health practitioners to fine-detail screening, because of the time and effort entailed, as well as their perception of minimal benefits to be gained, are also factors cited by a number of selected projects. Head Start became a provider, and remains one, to offset these circumstances.

b. Because of these factors, there was a tendency to place greater reliance on providers, probably reflecting either the prevalence of specialists in these fields who are not vendors, or the prevalence of resources within institutional entities which are not vendors, e.g., school districts, student-staffed clinics, etc.

c. Head Start projects tended to rely on proven resources rather than attempt to identify new resources. At least in some projects, non-Head Start children were served by vendors, whereas Head Start children were served by the project itself or another provider. Some of the projects indicated, however, that they questioned the medical screening provided by vendors but did not have the resources to bring all children within the gamut of their preferred approach to provider arrangements for fine-detail screening.

An interesting pattern is presented in the case of selected IMPD projects--reliance on a combination of vendors and providers. In the case of the Indian projects, this tendency reflects the important role of the Indian Health Service; whereas in the case of Fresno, it reflects the availability of migrant health program resources.

d. Overall, provider arrangements for the Head Start/EPSDT effort were dominated by vendors, but Head Start as a non-reimbursed direct provider, and other providers, continued to play an important role. Vendors were particularly predominant in the case of non-Head Start children for whom services were more likely not to be applicable.

3. Policy Considerations on Arrangements for Provision of Health Services

a. Head Start programs could be provided specific assistance in pursuing strategies to obtain reimbursement for special services they provide which can be paid by the EPSDT program.

b. Head Start programs could be encouraged to continue using public health resources in their community as a means of offsetting the limitations of the EPSDT program.

c. The success/failure of the EPSDT program rests quite clearly on the accessibility and availability of a full range of health services. Therefore, OCD might work very closely with SRS to strengthen the legislative and regulatory basis for the program as the first step in bringing about a more equitable allocation of local health resources.

F. OPERATION OF OUTREACH AND FOLLOW-UP

1. Analysis of Findings

Outreach

The selected projects used a variety of outreach methods to recruit non-Head Start children into the EPSDT collaborative effort. Outreach to non-Head Start children was concentrated on siblings of Head Start enrollees. Nineteen selected projects reported participation by non-Head Start children on intake forms. Four projects indicated that siblings accounted for 100% of the non-Head Start population. In six other projects, siblings accounted for 91% to 99% of non-Head Start children reached. Three projects--Leominster, Worcester and Baltimore--exhibited an opposite pattern.

Two of the selected projects did not report reaching any non-Head Start children. At Fort Peck, this situation resulted from the refusal of the local welfare office to provide a list of Medicaid siblings, and their active discouragement of Head Start outreach to non-Head Start children. The Danville project did not feel they had the time or resources to serve non-Head Start children.

Also, there was confusion in some Head Start projects as to the requirement to serve non-Head Start children. The intake data did not reflect any participation by non-Head Start children, including siblings, in the Toms River project, for instance. This project did serve a small number of this population, but the percentage could not be calculated from available information. A similar situation existed for the Blackfeet Tribe.

The success of the selected projects in reaching non-Head Start children who had been previously certified for Medicaid varied greatly acorss projects. Of the total number of non-Head Start children (4,389) reached by the selected projects in the collaborative effort, 711, or 16% of the non-Head Start children, had been previously certified.

The largest number of previously certified non-Head Start children reached by a single project was 1,443 in Paterson; in contrast, the smallest number of non-Head Start children in the category was 0 in the Blackfeet Tribe.

The variation by percentage of non-Head Start children who were Medicaid certified to the total non-Head Start children participating in the collaborative effort was, however, more noteworthy. The projects reaching the highest percentage of such children were Lubbock and Billings with 100%; but Lubbock only involved one child. Cook County and Medford reached the lowest percentages of previously certified children, 1% and 2% respectively. The median for the seventeen selected projects for which percentages could be calculated was 59%.

In reviewing this data, it appeared that those projects which reported large percentages of Medicaid eligible children actually recruited non-Head Start children whom they knew to be eligible. On the other hand, those projects with low percentages undoubtedly recruited in the general community.

Twelve projects reached non-English speaking children. The other thirteen were located in predominantly English speaking areas. It was interesting that all of the projects in Region I reached such children as did those in Region VI and IX, the latter being located in Texas and California, respectively.

Of the nine different outreach methods used by selected projects, the use of the Parent Involvement Component was the most frequently reported (21 of 23 projects) and was perceived to be the most effective method by thirteen projects. This method was the only form of outreach for non-Head Start children used by six projects. Through the Parent Involvement Component, Head Start projects were able to bring to bear existing program resources in the implementation of the EPSDT effort. They were able to disseminate information through the Parent Policy Council and through some actively engaged themselves to augment the outreach activity. Parent involvement staff, through their daily activities, were able to encourage parents to enroll the siblings of Head Start children into the EPSDT program.

The second most frequently used method for outreach was door-to-door-contact (12 of 23 selected projects) and was perceived to be most effective by outreach methods 75% of the selected projects using this method. Other methods such as mass media, literature, community organizations, etc., tended to be used less frequently. Two projects reported that they did not provide for any outreach to non-Head Start children.

All projects seeking to recruit non-English speaking non-Head Start children used bilingual outreach methods. Bilingual approaches were used by at least two projects for every type of outreach. In addition, eight projects reported that they used at least one bilingual outreach method. Overall, the effectiveness of these methods were perceived to be similar (on a proportionate basis) to methods described as non-bilingual. Mass media, community organizations and the telephone were the less frequently used method for bilingual outreach.

Follow-up

Both the SRS guidelines for EPSDT and the OCD guidelines for the collaborative effort reflected the importance of two components of a successful program. These two components were:

- Tracking, i.e., identifying services received against requirements with both screening and treatment by child
- Verification, i.e., insuring that services required by each child are received.

Some differences were reported between the tracking services provided for Head Start and non-Head Start populations based upon observations of recordkeeping systems and information obtained during the site visits. Head Start was the responsible agency for tracking Head Start children in 20 of the 25 selected projects. In the other five projects, the Head Start program was responsible for activities in conjunction with a public agency.

The adequacy of tracking for Head Start children was found to be good or excellent in 80% of the projects and adequate in the remaining 20%. In those instances where the public agency cooperated in providing tracking services, the projects tended to rate this service good for Head Start children and adequate or poor for non-Head Start children.

In the case of non-Head Start children, generally, tracking was found to be good or excellent in 40% of the projects where it was provided, adequate in about 25%, and poor in 35% of the projects. Although Head Start was also the dominant responsible agency in these instances, its role was less frequent (14 out of 21) as compared to the tracking provided to Head Start children. There was more frequent involvement of public agencies in providing tracking services for non-Head Start children compared to the Head Start group. Four projects indicated the public agency as the sole responsible agency for tracking and three others stated that the public agency provided this service in conjunction with the Head Start program.

For verification of services received, the responsible agency and adequacy were identified. Data also was obtained on records of services received and on control over non-Head Start providers of services. The existence of controls was differentiated by screening and treatment for both Head Start and non-Head Start children.

Head Start was the sole responsible agency for verification for Head Start children in 80% of the selected projects and shared this responsibility with a public agency in the remaining projects. The public agency was the responsible provider of verification for non-Head Start children for seven projects and shared responsibility with selected Head Start projects in three instances.

Head Start remained the dominant responsible agency for verification in 11 of 21 projects. The adequacy of verification was also similar to the pattern for tracking with the services provided to Head Start children again rated higher, i.e., 84% of the projects provided good or excellent verification for Head Start children and 16% were adequate, as compared to 42% of the projects providing good or excellent verification for non-Head Start children, 21% providing adequate services, and 37% providing poor services.

That better verification was provided for Head Start children than for non-Head Start children also held with respect to whether records of services were received by the responsible agencies or control exercised over the providers of screening and treatment services. All selected Head Start projects reportedly obtained a record of services received, and also exercised controls over other service providers in the case of Head Start children. Records of services received by non-Head Start children were not obtained in three projects and controls were not exercised over treatment in two projects where some activities were known to have occurred. For both record of services received and existence of controls, there was a substantial number of occurrences of "Not Applicable" or "No Information" (for instance, in Danville, Worcester, Amarillo, Appleton, and Springfield), probably indicating that minimal, if any, controls were exercised over non-Head Start children.

A comparison of the number of children participating in each project--Head Start and non-Head Start--with the various follow-up services seemed to indicate that program size bore no relationship to the adequacy of tracking and verification services provided.

2. Conclusions on Operation of Outreach

a. The Head Start Parent Involvement Component was found to be the most effective outreach method by the Head Start projects for recruiting non-Head Start children. Through the use of parent involvement, the projects were able to utilize existing program resources. Many projects also perceived door-to-door contact to be effective in reaching non-Head Start children.

b. The projects were highly successful in obtaining Medicaid certification for non-Head Start children who had not been certified prior to entry into the collaboration. They were relatively less successful with the Head Start population, reflecting possible discrepancies between the eligibility standards for Medicaid and Head Start.

3. Policy Considerations on Operation of Outreach

a. Because of the demonstrated success of the Parent Involvement Component in outreach, Head Start programs should be encouraged to fully utilize this resource in order to insure that all siblings of Head Start enrollees become participants in the EPSDT effort. Parent involvement staff as well as the Parent Policy Council should be provided specific training in this regard.

b. Door-to-door contact as a specific outreach method for EPSDT should be fully exploited, particularly during the period when the Head Start staff is recruiting children for enrollment in the Head Start program.

c. OCD might review with SRS the feasibility of providing Medicaid certification to low income pre-school children on the basis of their enrollment in the Head Start program. Because the income eligibility differences (in dollars) tend to be minimal between Medicaid and Head Start, the designation of Head Start enrollment as a specific eligibility standard for Medicaid/EPSDT could facilitate the certification of a particular group of low-income pre-school children for comprehensive health services.

4. Conclusions on Operation of Follow-Up

a. All Head Start children involved in the EPSDT Collaborative Effort received follow-up services, both tracking and verification. The Head Start project was usually the responsible agency for the provision of these services, and most projects deemed them adequate or better. The non-Head Start child was less likely to receive follow-up services, particularly verification.

b. The relatively low incidence of public agencies providing tracking and verification services suggests the lack of a systematic approach by state Medicaid/EPSDT agencies to the delivery of EPSDT in accordance with the federal regulations.

G. OPERATION OF RECORDKEEPING

1. Analysis of Findings

OCD guidelines specified that individual records were to be maintained for all children participating in the EPSDT Collaborative Effort. The Health Services bookkeeping system was suggested by OCD as a possibility for keeping records on non-Head Start children with recognition of acceptability of alternatives.

Recordkeeping provisions made by the selected projects were described by:

- continuity of contact, which identified whether these selected projects retained records for Head Start and non-Head Start children at the end of the program year, and also to whom records were transferred in the case of Head Start children
- impact of the EPSDT effort on recordkeeping, which identified whether the collaborative effort stimulated greater use of pre-existing forms or development of new ones
- quality of recordkeeping as reflected in the condition of records maintained by the projects.

About 75% of the selected projects retained health records for their Head Start children, whereas only 52% kept such records for non-Head Start children involved in the collaborative effort. Where the projects transferred records, the recipients were schools (seven times); combination of school and parents (six times); parents only (two times); and combination of school, parents, and provider (one time).

It should be noted that a provider was never a sole recipient of the child's health records. Of the nine projects retaining and transferring records on which information was available, 56% or five projects, transferred them to the combination of school and parents; 33% or three projects, transferred them to the child's school; and one to all possible recipients.

Only two of the 23 selected projects on which data was available, or about 10%, increased their use of record forms which had been used previously for Head Start children. Cleveland, Mississippi provided additional training for the center personnel responsible for recordkeeping and strengthening supervision of their efforts; Danville, Illinois emphasized more detailed and comprehensive completion of their existing forms.

Six of the projects on which information was available--27%--developed new, individualized forms for Head Start children due to the collaborative effort. A lower percentage--25%--developed such forms for non-Head Start children. Projects did, however, use various types of aggregate reports or records, according to site visit data. Many of these reports were copies of those supplied by the responsible local agency with all the inadequacies or variations thereof.

The contrast between the quality of project records maintained for Head Start and non-Head Start children was striking. For Head Start children, records were observed to be of good quality in 73%, or 18 of the selected projects; adequate in 24%, or 6 of the projects; and poor in only 4%, or 1 project. Conversely, records for non-Head Start children were observed to be good in only five projects, or 29%, and poor in eight projects (47%).

Supportive services were provided for non-Head Start children (seven of eight possible services) in most of the projects (21 of 25) and Head Start played a major role as the direct provider of such services.

2. Conclusion on Operation of Recordkeeping

Recordkeeping for non-Head Start children was considerably weaker than that for Head Start children. This condition is typical of the status of other supportive services for non-Head Start children as previously discussed. This pattern may reflect lack of resources, a factor noted in the site visits. No selected project, however, appears to have attempted to secure reimbursement for such services. Of equal interest is the minimal impact of the collaborative effort on Head Start projects' recordkeeping.

3. Policy Consideration on Operation of Recordkeeping

OCD might seriously consider requiring that records be kept on the provision of services to non-Head Start children comparable to those maintained on Head Start children . These would provide documentation of the medical care and follow-up received by these children and provide a basis for further study and comparative analysis between the two groups of children.

V. CHARACTERISTICS AND PREVIOUS CARE STATUS OF PARTICIPANTS IN THE HEAD START EPSDT COLLABORATIVE EFFORT

A. CHILDREN PARTICIPATING IN THE COLLABORATIVE EFFORT

1. Analysis of Findings

Information on the number of children participating in the collaborative effort was presented in the interim report (See Tables I and I-A).

The data on participation was based on the experiences of 120 projects (eighteen of which were selected projects) that submitted both Intake and End-of-the Year Status forms. Theoretically, intake and cumulative participation data should have been equal; however, many projects (both selected and other) did not submit intake forms for each child participating in the collaborative effort. In such instances, cumulative participation, i.e., total number of children served during the year was interpreted to include all children with whom the project had made contact.

Nationally, the Head Start projects provided services during the year to 74% of the planned service population. The selected projects showed a similar pattern as they reached 72% of their planned participation. There is some fluctuation in this pattern at the regional level, which most likely reflected differences attributable to the way in which the projects developed their projections. Further analysis indicated that 73% of the children served had completed the intake process.

Similarly, the various regions reflected this pattern, except for Regions I and III, where there was a greater evidence of non-sibling, non-Head Start children served.

There was a national turnover or drop-out of approximately 9,791, or 19% of the total number of children served (Head Start and non-Head Start). This pattern held true regardless of enrollment status, except for Regions IV and IX, where the turnover rate was less than 10%. However, in the case of non-Head Start children the pattern probably indicated the failure of many projects to maintain or track this particular group of children through all aspects of screening, diagnosis and treatment.

Eight of the selected projects reported service to more children than planned; and overall there was greater congruence between those served during the year and the rate of intake completion.

However, in one instance, Leominster, only 15 intake forms were submitted, yet there was a report of 335 children having been served sometime during the year. This project reported at the site visit that all Head Start children were receiving services comparable to EPSDT, and that, according to the grant application, they were restricting the target area to one small rural community. The project was advised of the necessity for completing intake forms on all Head Start children served by EPSDT.

In reporting participation during the year, several selected projects reported more service to non-Head Start children than planned. However, in all cases, comparable numbers of intake forms were not submitted. And in one case--Worcester--service to non-Head Start children consisted of simply informing the Head Start parent, at home interviews, that siblings were also eligible for EPSDT. This project did not complete intake forms or identify siblings of non-Head Start children who participated at intake, nor did it attempt to insure linkage or follow-up for the non-Head Start child. Medford reported serving 1,650 non-Head Start children but only submitted 45 intake forms for this group.

Discussion on Participation

There are several possible explanations for the variations noted in estimation and service totals for participating children. Information extracted from grant applications, telephone inquiries, and site reports suggested the importance of the following:

- The projects did not receive clear instructions from their respective regional offices as to the priorities and objectives of the Collaborative Effort.
- Many projects saw their function as providing public information rather than providing or arranging for direct services, which required additional manpower. Paterson, New Jersey is an example of a project with a large planned goal--nearly 5,000--which redefined its responsibility for service and submitted intake forms on only 152 children.

- The perception of the project staff prior experiences in preparing grant applications and proposals may have influenced the way they estimated for planned participation. However, the estimates do not seem to have been an important factor in funding for the collaborative effort Some projects presented low outreach estimates of service (10-50 children, for example) and still received funding from OCD.

- Weaknesses in some of the grant applications is another factor. Many projects reported that they were prepared hastily. Some projects defined clearly how their estimates were obtained--from census information, welfare rates, etc.--and carefully detailed their outreach strategies, but many proposals gave no rationale for how the service estimate was determined. In many cases, it appeared that projects either misunderstood their roles or failed to understand what the planned service entailed.

- As the tables reflect, the service estimates for Head Start children was more realistic than for the non-Head Start population. This pattern is logical because most projects simply reported their funding level. However, many projects had difficulty in making assessments of the number of non-Head Start children in need of service. Many proposals limited planned non-Head Start service to siblings. Others gave estimates of the number of children on welfare in the community but did not appear to have plans to serve or reach all these children.

Projects that recorded conservative estimates in their proposals appeared to come closer to meeting their goals as measured by the rate of cumulative/planned participation than projects that planned extensive participation. But the underestimaters should not necessarily be considered more effective in achieving their more limited goals.

2. Conclusions on Participation

a. During the first year of the collaborative effort, the Head Start demonstration projects were relatively successful in achieving the primary goal involving Head Start and non-Head Start children in EPSDT. Greater success was accorded the recruitment effort with Head Start children and their siblings because these children were easily accessible to the Head Start staff. Greater difficulty was experienced in reaching non-Head Start, non-sibling children possibly because of limited staff resources as well as the lack of clarity about the degree to which Head Start staff should be recruiting these children in the first instance.

b. The rate of turnover among the children served is comparable with other community programs serving preschool children. Allowing for the probability that the age of the child and family circumstances may have limited participation over time, it can still be concluded that staff resources were not fully utilized in maintaining children in the program.

c. Projects were less successful in carrying out their responsibilities to complete intake forms on participating children. This lack of information on individual children may limit the scope of the evaluation study by reducing the number of children for whom an assessment can be made regarding the impact of EPSDT on their health care status.

3. Policy Considerations on Participation

a. Systematic planning should be initiated as the first step in the development of a community health service program which involves major outreach activities. The service staff need to know how many children can realistically be served, where they are located, and the kind of supportive services needed so that they can properly deploy their staff resources.

b. If the Head Start program is to expand its responsibility to include the non-Head Start child, then there must be a definition of services to be provided to this particular population. Expectation that existing staff can extend their responsibility to include an expanding number of children is counterproductive and can lead to a diminution of services to all the children, Head Start and non-Head Start.

c. Head Start programs as a matter of policy should be mandated to include the siblings of Head Start children in the ongoing assessment of the health service needs. This population is readily accessible to the Head Start staff and should be considered an integral part of the program participants. Siblings, for purposes of the Head Start programs, should not only include those children who have blood relationships to the Head Start child but also those who live within the household and are part of the family structure.

d. For future provision of services, Intake Forms should be developed that are easily administered to increase the likelihood that the Head Start staff will obtain the kind of health care history necessary in order to insure greater utilization of EPSDT services.

B. MEDICAID STATUS OF PARTICIPATING CHILDREN

1. Analysis of Findings

Less than half (35%) of the total number of children served at any time during the first year of the collaborative effort were reported as Medicaid eligible. (See Tables II and II-A in Appendix A.)

For the selected projects the rate was 33%, and all other projects reported 37%. This overall level of eligibility was increased during the program year, to 49% eligible at the end of the year.

Comparison of eligibility at time of intake reveals that, nationwide, 37% of the Head Start children and 35% of the non-Head Start children were Medicaid eligible. With regard to Medicaid eligibility status at the end of the year, 37% of the Head Start children and 84% of the non-Head Start children were reported to be Medicaid eligible nationwide.

There was variation also at the regional level relative to the percentage of Head Start children eligible for Medicaid compared to participation at any time during the year. This regional variability in both participation at any time during the year and at intake could have reflected several factors:

- differences between the national poverty guidelines which establish the eligibility income levels for participation in Head Start and the state Medicaid eligibility standards
- differences in definition of the categorically and medically needy; the variation in state Medicaid plans* may be reflected here
- differences among programs in recruiting policies to enroll Medicaid eligible children; some accepted any child within the poverty guidelines or the 10% addition into their programs, others did not.

Medicaid Status Cumulative/End of Year

A comparison of Medicaid eligibility during and at the end of the year showed a decrease in the number of Medicaid eligible children. This reflected, in part, the turnover rate within the projects and the probability that Medicaid eligibility was a highly unstable status. In fact, many projects reported that the Medicaid eligibility status of their children shifted several times during the course of the year. This change in eligibility status created barriers for the effective delivery of services. For instance, a child was determined eligible for EPSDT and referred for screening; by the time treatment was needed, the child was ineligible for service. It should be clear, however, that not all of the children believed to be eligible at intake were subsequently certified for Medicaid, thus, their status as viewed by the project changed over the year from eligible but not certified to non-eligible.

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* In addition to the variations state to state, in some states eligibility determinations are made on the county level, and the income levels may differ between counties within one state.

A comparison of Other Eligibility Status (status unknown or ineligible), at intake to the end of the year, for Head Start showed a change in the reporting of "other" eligibility status. The national totals at intake reflected a high number in the "unknown" category (85%) of all "other" and a lower number (15%) in the non-eligible category. The reverse held true for the end of the year, with a greater number in the non-eligible category (77%) than unknown (13%). Nationally, and in every region, except Region IV, there was a decrease in the number of children in the unknown eligibility status and a corresponding increase in the number of non-eligibles.

This pattern most likely reflected that at intake a child's eligibility was unclear; but, as the year progressed, eligibility determinations were made, so that the exact status of the child was known. The "unknown" category at intake may have also reflected a project's procedures in determining eligibility at intake. Some projects accepted the statement of the parent regarding his financial status and others compared income information to state guidelines and made a more thorough assessment.

The difference between planned and actual participation was then examined relative to Head Start and non-Head Start children. The data indicated that, in general, the projects were much more successful in reaching their service goals for Head Start children than for non-Head Start children. Nationally, 108% of the planned service population was reached; while for the selected projects the figure was 111%.

It should be noted that those regions with higher concentrations of urban populations--Regions I, II, and V--had planned to serve more non-Head Start than Head Start children. This estimate might be explained by a greater number of low-income Head Start eligible families in these areas, and the tendency of projects in urban areas to utilize available community resources and to provide linkage of their families to these services. In regions where Head Start projects were the principal providers of services, and few outside resources were available, the service estimates tended to be more modest.

Intake Participation of Non-Head Start Children

The breakdown on the intake form by sibling status afforded the opportunity to analyze intake participation based upon familial relationship to Head Start enrolled children. Of the 38,417 children (Head Start and non-Head Start) who had completed intake only 15%, or 6,002 children, were non-Head Start, and 50% of these were siblings. For the selected projects, 11% of 5,182 children seen at intake were not enrolled in the Head Start program.

Nationally and in the selected projects over 50% of the non-Head Start Medicaid eligible children at intake were siblings of Head Start children. In both cases, the vast majority of the non-Head Start children were actual card carriers (Medicaid certified) rather than potentially eligible.

2. Conclusions on Medicaid Eligibility

a. Less than one half of the children participating nationally in the collaborative effort over the year were eligible for Medicaid. It would appear that the Head Start program had little appreciable impact in changing the Medicaid eligibility status of participating children, Head Start and non-Head Start alike. There is wide regional variation in this area, which probably reflects the initiative of individual projects in determining the status of their participating children.

b. The rates of cumulative participation and Medicaid eligibility tend to be higher, probably reflecting the relative ease of use of the reporting instruments for this data.

c. The differences in eligibility standards for Medicaid and Head Start services may have affected the number of children who were found to be Medicaid eligible by the projects. Those states with relatively low Medicaid standards may have been unable to accept low-income children recruited by the Head Start projects for the collaborative effort.

d. The data suggests by the decrease in the number of Medicaid eligible children at the end of the year that, allowing for turnover rates, many children experience change in their Medicaid status over the year. Fluctuations in the Medicaid eligibility status of individual children may have a detrimental impact upon the continuity of health care provided.

e. The marked change in the Other Eligibility Status for Head Start children from intake to the end of the year suggests a major effort by the projects to determine the Medicaid eligibility status of their participating children.

3. Policy Considerations on Medicaid Eligibility

a. Head Start health care personnel should have a thorough knowledge of the Medicaid eligibility standards in their state. This might aid in improving eligibility determination at intake and expedite the delivery of EPSDT services.

b. Medicaid/EPSDT eligibility determination could be made early in the program year so that Medicaid can pay for health services rendered, if appropriate, and the Head Start program can provide for follow-up.

c. Corollary to this, OCD could issue standardized procedures for assessing Medicaid eligibility by Head Start programs, to increase the accuracy and appropriateness of referrals for Medicaid certification.

d. There could be periodic redeterminations, possibly every six months, of Medicaid eligibility status by the Head Start programs, to maintain current, up-to-date information on the family's circumstances and minimize the probability that services will be cut off or delayed.

e. Head Start programs might establish working relationships with local EPSDT agencies to speed the determination and certification process of a referral child.

f. On a national level, there could be an in-depth review of the eligibility levels problem that exists in many states which creates barriers to EPSDT services for low-income children, particularly Head Start enrollees.

C. MEDICAID CERTIFICATION STATUS OF PARTICIPANTS

1. Analysis of Findings

Medicaid status was then analyzed through an examination of the certification patterns of those children categorized as Medicaid eligible. (See Tables III and III-A in Appendix A.) Certification referred to the status of each child deemed to be eligible as a Medicaid recipient by the state agency designated to authorize certification. Certification differed from eligibility in that it referred only to those children actually enrolled in Medicaid but not those who were potentially eligible though not yet certified. Only 88% of the children believed to be Medicaid eligible were actually certified at any time during the program year. Of the total number of Medicaid eligible children in the selected projects, 90% were certified at some point during the year, while 88% of the eligible children in the other projects were certified.

There was also variation at the regional level with respect to the relation of certification to eligibility in the Head Start and non-Head Start populations. This variation may have reflected either differences among projects in their eligibility screening and certification procedure; or their knowledge of the state Medicaid eligibility requirements. Some projects may have reported as Medicaid eligible only those children certified at the time of intake; whereas others might have reported all uncertified children believed to be eligible but later found to be ineligible. Additionally, the idiosyncracies of certification procedures most likely hampered and complicated certification and may have discouraged potentially eligible children from applying for Medicaid.

An analysis of Certification and Total Participation data showed that 49% of all children participating in the collaboration were Medicaid certified. At the regional level, the percentage of cumulative certification to total participation ranged from 24% (Region VI) to 77% (Region X).

Medicaid Certification Status Prior to Participation

A comparison of Medicaid certification status prior to intake into the program and Medicaid eligibility at intake revealed that 92% of children deemed eligible at intake had been certified prior to the program (91% in the selected projects and 92% in all other projects). This relatively high incidence of prior certification was found in all regions. With regard to Head Start children, 97% of all those eligible at intake had been certified prior to entering the program. This pattern also held across all regions.

Medicaid Certification Status at the End of the Year

Of all children remaining in the program or in contact with the program at the end of the year, 44% were Medicaid certified. There was a high degree of variation across regions ranging from a certification rate of 19% in Region VI to 72% in Region X. For the Head Start population, the range was from 16% to 62%. This variation might have reflected differential regional service patterns regarding the proportion of Medicaid eligible children served by the Head Start projects.

Of the non-Head Start children certified prior to the program, over 50% (2,658 out of 4,541) were siblings of Head Start enrollees. For the selected projects, the proportion of non-Head Start children who were siblings of Head Start enrollees increased to 71%. Notable differences existed in Regions I, III and IMPD projects where the greater proportion of non-Head Start children consisted of non-siblings.

2. Conclusions on Medicaid Certification

a. Head Start projects were reasonably successful in reaching and screening children for Medicaid eligibility, particularly in the case of non-Head Start children.

b. It should be noted that the projects' outreach techniques to non-Head Start children, in many cases, emphasized the recruitment of siblings of Head Start enrollees already certified, rather than siblings in Head Start families believed to be eligible but not yet certified.

c. It is also possible that some projects waited until certification was secured before selection. Those regions which reported lower non-Head Start certification rates may have been more effective in outreach.

d. Based upon observations made on the on-site visits the parent involvement component was generally useful in providing for outreach, screening, and establishing Medicaid eligibility, particularly with the siblings of Head Start enrollees.

3. Policy Considerations on Medicaid Certification

a. Head Start projects could be provided assistance in placing greater emphasis on developing outreach techniques that can bring more potentially eligible but not necessarily already certified children into EPSDT. In order to fully implement such a strategy, however, available staff resources must be considered.

b. Because of the demonstrated success in reaching siblings, the Parent Involvement Component in the Head Start program could be given even greater stress in its role to ensure that community resources are made available to all members of Head Start familes.

D. PREVIOUS HEALTH CARE: SCREENING OF HEAD START PARTICIPANTS

1. Analysis of Findings

Data was obtained to describe the previous health care, both screening and treatment, that had been received by participating Head Start and non-Head Start children, prior to their entry into the collaborative effort. This information served as the basis for measuring the impact of the collaborative effort as shown by the extent that health care was received during the program year.

The health screening status of Head Start children prior to their entry into the EPSDT Collaborative Effort (Table IV and IV-A in Appendix A.) was collected from the intake forms completed by the projects, which requested information on screening obtained within the year prior to entry. The data reported were directly related to the parental ability to recall the child's health care history.

On the national level, 22% of the Head Start children had been enrolled previously in Head Start. The largest number of children carried over from the previous year occurred in the IMPD projects where over one out of three Head Start children had been previously enrolled. Carryover of children was less prevalent in Region IX, where less than 10% of the children had been enrolled in Head Start previously.

The status of prior enrollment in Head Start was important in reviewing screening services received prior to the collaborative effort as the Head Start program is responsible under the OCD Performance Standards for providing health screening to all its enrollees. In general, the role of Head Start as an effective supplier of health screening services was shown by the higher level of such screening among previously enrolled Head Start children.

On a national basis, 92% of the children participating at intake who had been previously enrolled in Head Start had also received screening, as compared to 63% of children not previously enrolled who had been screened. Although the trend is less strong among the selected projects, at 79% to 45%, prior enrollment in Head Start appeared to be most closely related to prior receipt of screening services.

The principal deviation from this trend appeared in the IMPD projects, where only 56% of the children formerly in Head Start had been screened compared to 52% of not previously enrolled children who had been screened.

Medicaid Certification/Prior Screening Services

At the time of intake, 41% of the Head Start children participating in the EPSDT Collaborative Effort were Medicaid certified, 3% were classified as not certified and 56% as "other" (not eligible or Medicaid eligibility unknown). Although it was expected that Medicaid certified children would be better able to obtain health services and be screened more frequently than the uncertified children, a child's status regarding Medicaid certification did not in fact, have a strong influence on receipt of screening services overall.

On a national level, the proportion of Head Start children who had received screening was nearly identical in both instances: 71% of the Medicaid certified and 70% of the not Medicaid certified. Such finding is to be expected because the Performance Standards require screening of all Head Start enrollees.

In the selected projects, the prevalence of prior screening among the previously enrolled population was generally high--in five projects, 100% of the previously enrolled Head Start children had been screened prior to intake. However, there were also marked deviations from this pattern. In Lubbock, only 20% of the previously enrolled had been screened prior to intake; and in East St. Louis, only 36%.

The Medicaid certification status of Head Start children screened varied among the selected projects. Of the projects reporting children who had received prior screening services, 12 stated that over 70% of the entire Medicaid certified group had been screened before enrolling in the 1974-1975 Head Strat program year. On the other hand, one project reported no Head Start children who had been screened were Medicaid certified. There was some difference between the prevalence of screening received by Head Start children classified as "Other" within the selected projects (40%) and on the national level, where it averaged 67%.

2. Conclusions on Previous Health Care: Screening of Head Start Participants

a. Relatively few Head Start children were carried over from the previous program year as reflected in the national average of 22%. It appeared that most children enrolled in Head Start only have one year's experience except for such specialized Head Start programs as IMPD.

b. For those children enrolled, the Head Start program had been highly successful in obtaining screening services which suggests significant compliance with OCD Performance Standards, although the exact nature and extent of screening services obtained are unknown.

c. Less than 50% of the Head Start children participating were Medicaid certified, which suggests that Head Start programs relied to a great extent upon their own program resources to provide screening services

d. The wide variation in Medicaid certification among the selected projects most likely reflects local conditions, such as the availability of community health resources, flexibility in the provision of Medicaid services within the state, and the initiative on the part of the individual project to utilize community resources.

3. Policy Considerations on Previous Health Care: Screening of Head Start Participants

a. Since most children enrolled in the Head Start program benefit from these services for only one year, every effort should be made to ensure that all enrolled children receive screening services early in the program year so that adequate follow-up can be made. High priority might be assigned by OCD for monitoring individual programs for compliance with the Performance Standards in this regard.

b. Head Start programs could be provided assistance to ensure greater utilization of community health resources for the provision of screening services to augment their own program resources. This objective of the EPSDT Collaborative Effort as a specific program strategy appears to have much merit.

E. PREVIOUS HEALTH CARE: TREATMENT RECEIVED BY HEAD START PARTICIPANTS

A profile of treatment received by Head Start children during the year prior to enrollment was provided for all demonstration projects in Table V (see Appendix A). Treatment included medical, dental, mental health and nutritional services. The treatment categories were stratified by the Medicaid certification status of the children, i.e., children who are Medicaid certified, children not certified but eligible, and "other" (children whose Medicaid eligibility was unknown or who were in fact, ineligible). Information was not obtained regarding previous health care in relation to diagnosis. It was assumed that, in those instances where treatment had actually been received, diagnosis would have, of necessity, been made.

1. Analysis of Findings - National Sample

Medical Services

In the total national Head Start sample 5,500 (10% of the participating population) received medical treatment the year prior to enrollment. In the regions, the proportion of children who had received prior medical care ranged from 8% to 28%. Prior receipt of medical treatment was nearly evenly divided between those children who were Medicaid certified or eligible but not certified (2,641) and those classified as "other" (2,759). The child's status in this regard did not appear to have played any role in the receipt of medical care.

There was, however, regional variation in the receipt of medical treatment by the child's certification status. In Region IV, only 31% of the children who had received medical treatment were Medicaid certified or eligible, whereas in Regions I, II, and VII approximately 70% of the children who had received medical treatment were Medicaid certified or not certified but eligible. One factor that may have been operating is that State Medicaid Plans differed in the availability of treatment services. These differences would then govern the receipt of services by the Medicaid certified.

Dental Services

Approximately one out of three Head Start children had received dental screening/treatment prior to the collaborative effort. Region VIII's Head Start population had the greatest proportion of children who had prior dental services (58%). At the lower range of the scale, only 23% of the children in Regions I and V had received treatment.

The number of children who had received dental screening/treatment and who were classified as "other," i.e., ineligible for Medicaid or of unknown status (6,204) exceeded the number of Medicaid certified and eligible but not certified (5,039) receiving such care. The major deviation from this pattern occured in Region IV where only 703 of the Medicaid certified or eligible children received dental services but 1,589 (1/2 ratio) in the "other" category received such care.

Mental Health Services

Mental health services were received by a far lower proportion of children than received medical and dental care. Only 6% of the children participating in the Head Start/EPSDT effort received such services in the preceding year. The lowest incidence of mental health services prior to enrollment in the collaborative effort occurred in Regions I where 2% of the 1,882 Head Start population participating received services, compared to the highest rate of 22% services received in the IMPD projects.

Again, Medicaid certification did not appear to play a major role in receipt of mental health services. Nationally, 1,090 children who were Medicaid certified or eligible for such status received services and 1,149 children who were eligible or of unknown status also received care.

Nutritional Services

Nutritional services were received by only 3% of the Head Start population, and was therefore the least frequently obtained type of previous health care. A notable deviation occurred in the IMPD projects where 24% of the children had received nutritional care before enrollment in the collaborative effort. This difference apparently reflected the availability of resources for nutritional care in these communities. In addition, it may have reflected a more nutritionally deficient environment for children entering Head Start in these areas.

2. Analysis of Findings - Selected Projects

Previous medical, dental, mental health, and nutritional services received by Head Start children for the year prior to entry into the collaborative effort for 18 selected projects was also identified. (See Table V-A of the Interim Report) within each area of service the children are differentiated by their Medicaid certification status.

In the selected projects, an average of 10% of the children entering the program had received medical treatment within the previous year and was consistent with the national average, A wide range was evident in the medical treatment/participation ratio; for instance, little or no children had been treated in Toms River, East St. Louis, Lubbock, Blackfeet and Fort Peck, but 46 out of 132 children had received such care in Medford, Oregon. Because the profiles of the projects with low incidence of medical services received differ greatly, it was difficult to surmise reasons for this varying behavior.

Medicaid Certified and eligible but not certified children in the selected projects received medical treatment to a greater extent than those in the "other" category: 338 to 159.

In the selected projects, approximately one quarter of the children received dental screening/treatment services. The range in the receipt of these services was broad: from 2 out of 231 children in Lubbock to a high of 118 out of 119 in Springfield.

The receipt of mental health services by children in the selected projects occurred at a rate of 50%. The rate varied from no children in Leominster, East St. Louis and Eugene to all children enrolled in the Springfield Head Start project. Although the IMPD projects had a high proportion of children who had received mental health services (24%), the average rate of receipt in the selected IMPD projects was less than 1% which may reflect the lack of resources in these areas.

Previous receipt of nutritional services among children in the selected projects was at the rate of 1%, even less frequent than on the national level. Nine selected projects reported that none of their Head Start children had received nutritional services prior to entering the program. The IMPD regional data showed a significantly higher receipt of nutritional services than in the IMPD selected projects. The lack of provision for nutritional services in the Montana State Plan may have been an important contributory factor to the less frequent receipt of such services, since two of the three IMPD projects are in that state.

3. Conclusions on Previous Health Care: Treatment

a. Greater proportions of Head Start children received dental screening/treatment than any other service. The higher incidences of dental screening/treatment service received may reflect the impact of the OCD Performance Standards

b. Only 10% of the Head Start children had received medical treatment prior to entry into the collaborative effort. Medicaid certification or eligibility appears not to be a factor related to whether such services had been received. To the extent that regional variations existed, this probably reflected differences in the availability of medical services under the State Medicaid Plan. The receipt of nutritional and mental health services prior to entry was far less common among all reporting projects.

c. The differences in the incidence of various health services received may reflect the availability of these services in the particular area, either through Medicaid or private health resources; priorities set by the projects themselves regarding the relative importance of these services and/or actual needs.

4. Policy Considerations on Previous Health Care: Treatment

a. Head Start programs might be provided assistance in gaining greater awareness of overall developmental health needs of pre-school children with particular stress upon mental health and nutrition.

b. OCD could press for national standards for the provision of health services to low-income preschool children, thereby avoiding the dearth of service provisions triggered by limitations in individual state plans for Medicaid/EPSDT.

F. PREVIOUS HEALTH CARE STATUS OF NON-HEAD START CHILDREN

1. Analysis of Findings - National Sample

Of the 6,002 non-Head Start children who completed intake, 73% of this group were Medicaid certified and 2 out of 3 of these were siblings of Head Start enrollees.

Screening Services

Out of the total non-Head Start children participating, 59% had been screened prior to coming into contact with the EPSDT Collaborative Effort. There was variation in the proportion of screened to participating children across regions. The percentage of children who had received screening ranged from a low of 38% of non-Head Start children in Region VII to a high of 92% of such children in Region IX.

On a national basis, a majority of non-Head Start children, 75% who had been screened were certified or not certified but eligible for Medicaid, compared to 71% of the Head Start population. This pattern was consistent with the data for Head Start children. It should be noted that siblings of Head Start children accounted for over 50% of the Medicaid certified population that had been screened.

The certification profile for the non-Head Start child who had been screened varied by region from 46% to 99% of the non-Head Start population. In Regions I, III and the IMPD projects, more non-siblings than siblings had been screened who were Medicaid certified.

Medical Treatment

Nationally, one in five non-Head Start children had received medical treatment within the year prior to the involvement with the collaborative effort. 80% of those receiving this treatment were Medicaid certified and, with respect to sibling status, about half were siblings of Head Start children. This pattern of high incidence of Medicaid certified non-Head Start children receiving treatment prior to the collaborative effort held true across all regions. Five regions reported that they had more non-siblings than siblings who had received such services however.

Dental Services

Among the non-Head Start children, one out of five also received dental screening/treatment as compared to one out of three Head Start children. The highest incidence of receipt of dental services occurred in Region VIII where 41% of the children had received dental services prior to the collaborative effort. This region had the highest proportion of Head Start children receiving dental services also. The lowest incidence of such services received was reported in Regions IV and VII at 11%. However, most of the regions approximated the national average.

85% of the non-Head Start children who had received dental services were Medicaid certified, and over 50% of these (621 out of 1,101) were siblings of Head Start children. Of the not Medicaid certified group, slightly more than 50% were non-siblings. This pattern held true across all regions with an increase in Regions V and VII where almost all the non-Head Start children receiving dental services were Medicaid certified. In reviewing the sibling dental services, Regions, I, III, V, and the IMPD projects reported that the greater number of non-Head Start children who were Medicaid certified were non-siblings.

Mental Health Services

On the national level, 3% of the non-Head Start children had received mental health services within a year of entering the colaborative effort compared to the national average of 6% for Head Start children. The IMPD projects deviated more sharply from this average with 11% of these children having received mental health care prior to involvement with the collaborative effort. Region I had the next highest proportion of non-Head Start children receiving mental health services at 10%. In four regions, 1% or less of the non-Head Start children had received mental health services. In each region, nearly all of the non-Head Start children receiving mental health services prior to entry were Medicaid certified, and most of them were siblings of Head Start enrollees. The high incidence of Medicaid certification among non-Head children receiving mental health service differs markedly from the Head Start population where Medicaid certification was not a distinguishing factor among those children who had received mental health services prior to entry into the program.

Nutritional Services

Of the non-Head Start children participating at intake, 4% of them had received nutritional services prior to entry. Again, for the non-Head Start population, the receipt of such service appeared to be related to Medicaid status: more than three-fourths of the children receiving nutritional services were either certified or eligible.

As with the previous categories of health services, the majority, 61% in the case of nutritional services, of the non-Head Start Medicaid certified participants were siblings of Head Start enrollees. In Region III, V, VI and the IMPD projects, there was some deviation from this pattern with a higher number of non-siblings or other/unknowns being recorded.

2. Analysis of Findings - Selected Projects

The total number of non-Head population who completed intake within the selected projects was 783 or 13% of the national total. Of the 18 selected projects under review, four--Toms River, Danville, Blackfeet and Fort Peck--did not report any intake of non-Head Start children.

82% of the non-Head Start children participating in the remaining 14 projects were Medicaid certified and 75% of these were siblings of enrollees. Of the non-Medicaid certified group, none were non-siblings. 48% of the non-Head Start children in the selected projects had been medically screened within a year prior to enrollment as contrasted to 59% of non-Head Start children nationally who had received such services. Of the medically screened in the selected projects, 52% were Medicaid certified. Most of the selected projects that served children who had received screening prior to entry reported a higher incidence (over 50%) than the average. However, East St. Louis and Amarillo reported one child or less in this category, thereby skewing the average.

Of the non-Head Start children screened, 90% were Medicaid certified and more than half were siblings of enrollees. This pattern holds true in all projects except Baltimore where almost all non-Head Start Medicaid certified children screened were non-siblings. Baltimore also reported three not Medicaid certified non-siblings screened, but indicated no non-siblings at intake. This inconsistency most likely reflected the project's failure to submit the appropriate number of forms (Intake and Health Encounter) for each non-Head Start child served.

Among the 14 projects reporting non-Head Start children participating in the program, 8% of these children had received medical treatment within a year of enrollment. This was a lower ratio than that for the national sample, one out of five non-Head Start children in receipt of such services. The highest incidence of previous medical treatment received--49%--occurred in the Medford project. Six projects reported that none of the non-Head Start children participating at intake had received medical treatment. 80% of the non-Head Start children who had received medical treatment were Medicaid certified as well as siblings of Head Start enrollees.

Nearly one out of four of the non-Head Start children received dental screening/treatment in the selected projects. In contrast, one out of five non-Head Start children had received dental services in the total sample. The overwhelming majority of the non-Head Start children in this group were Medicaid certified and siblings of Head Start enrollees, except in Baltimore where all of the non-Head Start children receiving dental services were non-siblings. In six projects, none of the non-Head Start children received dental services.

In another area, mental health services, 7% of the non-Head Start children in the selected process had received such services compared to 3% of these children on a national basis. Medicaid certification of non-Head Start children in the selected projects may have influenced the receipt of mental health services, since 56 out of 58 of the non-Head Start children were Medicaid certified or eligible. This rate was somewhat higher than the national pattern (shown in Table VI - Appendix A) for non-Head Start children. 55 out of the 58 non-Head Start children who had received mental health services were reported to be participants in the Paterson project, and nearly all of these were Medicaid certified and siblings of Head Start enrollees. Eleven projects, on the other hand, indicated that none of their non-Head Start children had received mental health services prior to entry and one project had only one child who had received mental health services.

Similarly, only three projects reported that their non-Head Start children had received nutritional services prior to program entry. Paterson again reported the majority of the children--54 out of 56 non-Head Start children--so reported. As in mental health services, nearly all of the children in the Paterson project were Medicaid certified and siblings of Head Start enrollees.

3. Conclusions Previous Health Care: Non-Head Start children

a. The majority of the non-Head Start children participating in the collaborative effort as evidenced by the completion of intake forms, were Medicaid certified and two out of three children were siblings of Head Start enrollees. It would appear, therefore, that the Head Start projects primarily recruited non-Head Start participants for the collaborative effort from the Head Start families currently enrolled.

b. 59% of the non-Head Start children as compared to 69% of the Head Start children had received screening services prior to entry into the collaborative effort. This similarity in incidence, accounting for sampling bias, may reflect concentration by some Head Start projects in providing for family health services rather than focusing upon the enrolled Head Start child only.

c. Relatively few, approximately 20% of the non-Head Start children, received medical treatment services prior to entry into the program, but most of these were Medicaid certified.

d. The incidence of dental services received was lower for non-Head Start children than Head Start children--one out of five compared to one out of three. This difference most likely reflects the priority placed in the Head Start projects upon providing dental services for its enrollees.

e. There were some differences in the receipt of mental health and nutritional services between Head Start and non-Head Start populations nationally. However, because of the relatively low number of participants receiving these services, no conclusions should be drawn. It is interesting to note, however, that most of the non-Head Start children receiving mental health and nutritional services were Medicaid certified.

e. For the selected projects, the distribution of non-Head Start children by service category, Medicaid certification, and sibling status is similar to the pattern presented nationally. Baltimore, which served more non-siblings than siblings is a notable exception.

f. Prior mental health and nutritional services are virtually nonexistent for non-Head Start children except in the case of Paterson. The fact that this particular project was able to be garner such services for its non-Head Start children may reflect the availability of resources in the community, including liberal Medicaid standards, and the initiatives by the project's staff to secure services for all its participants.

4. Policy Considerations on Previous Health Care of Non-Head Start Children

a. Head Start programs should be encouraged to arrange for family health services, thereby ensuring that all family members, including the children, have comprehensive health care. Such program initiative, however, must take into account limited staff resources.

b. If the EPSDT collaborative effort is to be effective, Head Start projects should be assisted in defining their responsibility for recruiting participants beyond the immediate Head Start family. Within this context, OCD should clarify with the Social and Rehabilitation Services unit the extent to which Head Start programs should be responsible for recruiting participants in the general community.

VI. INDICATORS OF EPSDT PERFORMANCE

Introduction

The Head Start projects sought as a major priority to provide or obtain EPSDT services for children participating in the collaborative effort. They were concerned, moreover, with ensuring access to a continuity of medical services for children who were found to be in need of such care.

A significant task for the evaluation study, therefore, was to ascertain the effectiveness of the projects in obtaining EPSDT reimbursable services for Medicaid certified children, both Head Start and non-Head Start. In addition, for non-Medicaid eligible children, there was particular interest in determining the extent to which health services were provided or obtained in relation to the children's Head Start enrollment status.

In order to accomplish this task, several indicators to measure effectiveness were established within the following parameters: (a) the extent to which children received various health and medical services this year compared to the number who received such services prior to the collaborative effort; and (b) the relationship, if any, between the numbers reported and Medicaid certification and Head Start enrollment status. These indicators were based upon the asumption that increases in the numbers of children receiving health services, particularly through EPSDT, can be attributed to the collaborative effort.

This section, therefore, presents data on the extent to which Head Start and non-Head Start children received medical, dental, mental health and nutritional services according to their Medicaid certification and previous enrollment in Head Start. The following tables are included.

Medical Services	- Screening by Aggregate Totals	Table XVI-A
Medical Services	- Screening of Head Start and non-Head Start Children by Selected Projects	Table XVI-A$_1$
Medical Services	- Diagnosis and Treatment by Aggregate Totals	Table XVI-B
Medical Services	- Diagnosis and Treatment of Head Start and non-Head Start Children by Selected Projects	Table XVI-B$_1$
Dental Services	- by Aggregate Totals	Table XVI-C
Dental Services	- of Head Start and non-Head Start Children by Selected Projects	Table XVI-C$_1$

Mental Health Services	- by Aggregate Totals	Table XVI-D
Mental Health Services	- of Head Start and non-Head Start Children by Selected Projects	Table XVI-D_1
Nutritional Services	- by Aggregate Totals	Table XVI-E
Nutritional Services	- of Head Start and non-Head Start by Selected Projects	Table XVI-E_1

The data for those tables related to aggregate totals was collected from the Compositive Visit and Health Care Encounter forms submitted by the Head Start projects. There were 147 projects submitting such data, representing an increase of 21% from the number of projects (120) which were reported on previously.

For the selected projects, data on the health services received by individual children was reported on the Health Care Encounter form, and a total of 23 projects submitted these; a gain of five from the previous reporting period. (See Intrim Report Tables I - VI-A in Appendix A.)

Note: In many of the tables, the figures in the various categories (crosswise) will not agree with the totals shown in Column 1 because of a "no response" by the respective demonstration project to the specific category area. Also, the tables mentioned above will be included at the end of each major discussion section.

A. MEDICAL SERVICES - SCREENING (TABLES XVI-A, XVI-A_1)

Definition of Terms

The aggregate number of children who actually received screening services during the program year is identified by Head Start enrollment and Medicaid certification status for both the national sample and selected projects in Table XVI-A. Data pertaining to the receipt of screening services in individual selected projects is presented in Table XVI-A_1 for Head Start children and non-Head Start children.

Cumulative Participation refers to the total number of children served by the projects during the year as reflected in Tables I and IA. (See Appendix A.)

Children Previously Screened refers to the total number of children whom the projects reported as receiving screening services prior to their entry into the collaborative effort. This data has been carried forward from Tables IV and IVA. (Appendix A).

Children Screened During Program Year refers to the total number of children reported as receiving screening services during first year

Children Completely Screened During Program Year refers to the total number of children who received the complete package of screening services that was recommended by the Health Advisory Committee of the local Head Start project

Screening Incomplete/Follow-up Required refers to the total number of children who did not receive the complete package of screening services or needed further screening or diagnostic evaluation.

Cases Referred refers to children sent to other sources for further assessment and/or treatment.

Cases Completed refers to children who received the complete range of needed services.

1. Findings of Analysis

Children Screened During Program Year (C)

Aggregate Totals

The total number of children screened increased fourfold from the twelve-month period immediately prior to the Head Start/EPSDT Collaborative Effort as reported by 147 projects participating nationally. Of the 95,997 children screened, 86% were enrolled in the Head Start program itself, compared to 90% previously. For the 23 selected projects submitting data, there were 7,424 children reported as screened, compared to 2,616 previously--an increase of 3 to 100and 92% of these were Head Start enrollees.

All regions except Region III reported increases in the total number of children screened that, when compared to the previous year, were comparable or greater than the national ratio of 4 to 1. Most of the percentage increase in the number of non Head Start children screened this year can be accounted for by the gains in Regions IV and VI.

Selected Projects

Twenty-two out of the 24 selected projects participating in the collaborative effort submitted information regarding the receipt of screening services for individual children. This information was coded by Head Start enrollment (current and prior) and Medicaid certification status.

Laredo and Blackfeet submitted the required health related forms for analysis, but each failed to properly indicate the program and child identification number. This made linkage of information between the Health Care Intake Form and the Health Care Encounter Form--re: Medicaid status, previous and current health services received, etc.--virtually impossible. Reconciliation was not feasible through telephone contact with the projects and would have involved an excessive amount of time for the projects themselves to correct. Unfortunately, this information could not be included as a part of the evaluation study.

There was a threefold increase (6,883/2,616) in the total number of Head Start children screened this year in the selected projects as compared to the number previously screened (22 projects reporting). The largest number of Head Start children screened was reported by Cleveland, Mississippi (2,456). For projects that had reported previously, the greatest percentage increases were in Cook County, East St. Louis, Danville, Lubbock, Amarillo and Billings. On the other hand, three projects--Baltimore, Springfield and Eugene--reported the same or a decrease in the number of children screened this year.

Only 34% (2,427 out of 6,883) of the Head Start children screened during the year had, however, been previously enrolled in the program. This incidence was higher than the 29% of previously enrolled Head Start children who had been screened prior to the collaborative effort (See Table IV-A, Appendix A). Baltimore, on the other hand, reported that almost 50% of its Head Start children who were screened this year had been previously enrolled. Seven projects, however, Leominster, Worcester, Toms River, Dayton, Lubbock, Fort Peck and Eugene--had less than 5% of their Head Start children previously enrolled.

There is no clear indication whether Medicaid certification had any bearing on the total number of Head Start children screened since 50% of these children (3,470 out of 6,883) were Medicaid certified and over 49% were either ineligible for Medicaid or of unknown status. Thus, only one-half of the Head Start children screened could have possibly received such services through the EPSDT system.

Sixteen projects (compared to 22 reporting screening of Head Start children) submitted data on the screening of non-Head Start children. This represents a gain of four projects from the previous reporting period (see Table IV-A in Appendix). Projects not submitting data, besides Laredo and Blackfeet, included Toms River, Danville, Lubbock, Fort Peck, Fresno and Eugene. It is interesting to note that Laredo and Eugene had reported non-Head Start children as receiving screening services prior to the collaborative effort. On the other hand, Toms River, Danville, Lubbock, Fort Peck, Blackfeet and Fresno did not report for either period.

Of the projects reporting, there was 541 non-Head Start children screened this year, an increase of less than 50% from those reported screened prior to the collaborative effort. (Table XVI-A_1). The highest actual number of non-Head Start children screened occurred in Cleveland (252). The next highest was Paterson, with

52. The majority (65%) of the non-Head Start children screened were siblings, and for 7%, their kinship relationship to Head Start children was "other" or not known.

Most of the non-Head Start children screened (500 out of 541) had not been previously enrolled in Head Start. Only Medford reported a majority of its non-Head Start children (16 out of 25) as previously enrolled.

A greater proportion of the non-Head Start children (82%) were Medicaid certified, as compared to the incidence reported for Head Start children. Of the Medicaid certified group, the majority (62%) were siblings of Head Start enrollees. Thus, Medicaid certification may have been a factor in the receipt of screening services for non-Head Start children this year, with the likelihood that such services were EPSDT reimbursable.

Children Completely Screened (D)

Aggregate Totals

Nationally, 30,540 out of 95,997 children screened--Head Start and non-Head Start--or 31%, received the complete package of screening services as recommended by the local Head Start Health Advisory Committee (Table XVI-A). For the selected projects, the percentage of children who had complete screenings was much higher at 70% (5,288 out of 7,424).

Either selection bias or the sensitivity of the projects to completing the screenings because of their special status may have accounted for this wide variation. Head Start children were by far the majority (81% or 24,884 out of 30,540) of those children reported completely screened. However, only 29% of the Head Start children screened nationally had the complete package--24,884 out of 82,782.

At the regional level, only four regions exceeded the national average of 31% of children completely screened--Regions V, VI, IX and the IMPD projects, with 35%, 33%, 34% and 38% respectively. Three regions--VIII, IX and the IMPD projects--reported a greater proportion of their Head Start children completely screened compared to the national totals--37%, 40% and 34%, respectively. Two regions were much lower--Region II at 16% and Region VII at 10%.

The proportion of non-Head Start children who had complete screenings nationally was slightly higher at 34%. Three regions--Regions II, VII, and X-- greatly exceeded this percentage at 50%, 55%, and 50%, respectively.

Selected Projects

The Head Start children enrolled in the selected projects usually received complete screenings, representing 73% of the total screened. (Table XVI-A.) Moreover, 17 of the 22 projects reporting indicated even greater proportions of completely screened Head Start children than the average cited above, with Amarillo stating that all of its 626 children were in this category and Springfield, 114 out of 117.

Approximately 37% of the Head Start children completely screened had been previously enrolled in the program. In Cleveland, however, the vast majority of such children had been in Head Start during the prior year, and in Fresno, all 56 children completely screened had been in the program before. The majority of the projects, however, reported greater numbers of Head Start children completely screened as not previously enrolled. One-half of the Head Start children completely screened were Medicaid certified; the other half were mostly coded as ineligible or status unknown.

For non-Head Start children, 73% (398 out of 541) had complete screenings, and nine of the sixteen projects reporting indicated that a majority of their Head Start children had been completely screened. In Paterson, for instance, all non-Head Start children were completely screened. Three out of four of these children were siblings, and over 95% had not been previously enrolled in Head Start. For Medicaid, 89% (331 out of 398) were certified and the majority of these children (283 out of 331) were siblings. It should be noted that Cleveland accounted for 211 of these children (Table XVI-A_1).

Screening Incomplete/Follow-up Required (E)

Aggregate Totals

Follow-up services were required for the majority of children screened nationally (68%) because screening had not been completed. The data is insufficient, however, to determine the nature of screening services still needed. Also, there is no information regarding the relationship between the availability of a full range of screening services and extent of completion, or the impact of program management (length of time required to complete screening and subsequent preparation of forms, etc.). On the other hand, only 29% of the total children screened in the selected projects required follow-up services. Most of the regions followed the national pattern, with Regions I and VII reporting even higher percentages of incomplete screenings at 77% and 81%, respectively.

The proportion of incomplete screenings for Head Start children compared to total number screened was higher than the national average at 69% (57,898 out of 82,782). Three regions--I, II, and VII--were even higher at 79%, 83% and 82%,rrespectively. The lowest rate was reported by Region IX, 59%.

The rate of incomplete screenings was much lower for non-Head Start children nationally at 49% (7,559 out of 13,218). Four regions--I, III, VIII and IX--were much higher at 77%, 55%, 57% and 73%, respectively. Interestingly, the IMPD projects reported only 1% of their non-Head Start children as having incomplete screenings.

Selected Projects

About 28% (1,993 out of 6,883) of the Head Start children screened in the selected projects required follow-up services. Sixty-nine per cent these children (1,381 out of 1,993) had not been previously enrolled in Head Start and 53% were Medicaid certified.

Eleven projects reported substantially lower proportions of Head Start children receiving incomplete screening, compared to the overall average of 28%. Amarillo, for example, reported that none of its Head Start children required follow-up, and Springfield indicated that only three of its 117 children were in this category.

For those projects reporting relatively low numbers of children with incomplete screenings, the majority or all of their Head Start children requiring follow-up had not been previously enrolled. In this instance, their behavior did not differ from other projects who had greater numbers of Head Start children needing follow-up.

Medicaid certification status appears not to have been a factor in the extent to which the projects were able to complete screenings of Head Start children. Eight out of 11 projects with relatively few Head Start children needing follow-up indicated that a majority of them were Medicaid certified. In Cleveland, however, over half (505 out of 940) of the Head Start children with incomplete screening were either ineligible for Medicaid or of unknown status.

Only 26% of the non-Head Start children screened required follow-up services, and most of these (136) had not been previously enrolled in Head Start. Nine of the 16 projects reporting stated that a majority of their non-Head Start children had complete screenings. Less than half (41%) of those children requiring follow-up were siblings of Head Start enrollees and, of the total number of non-Head Start children in this category, 82% were Medicaid certified.

2. Conclusions on Receipt of Medical Services - Screening

a. Four times as many children were screened nationally this year, compared to the incidence reported prior to the introduction of the EPSDT Collaborative Effort. The overwhelming majority (86%) of children screened were currently enrolled in the Head Start program. This finding indicates that the projects made a special effort to ensure that their Head Start children were promptly screened and reported.

b. The Head Start projects were less successful in ensuring that complete screenings were provided, since only 31% of the children were reported in this category. This low incidence, however, may have been the result of a time lag in the reporting, or an indication of the availability/accessibility of a full range of screening services/providers.

c. Of the Head Start children screened in the selected projects only 34% had been previously enrolled. Thus, the projects primarily screened children who had not been known to Head Start previously and who, therefore, were unlikely to have previous screening.

d. No conclusions can be drawn regarding the impact of Medicaid certification upon receipt of screening services, since the number of children certified vs. those whose eligibility was unknown or ineligible was about equally divided.

e. The number of non-Head Start children screened in the selected projects increased by less than 50%, compared to those previously screened. This increase was not as dramatic as that reported for Head Start children, however. The projects may have concentrated their efforts on screening (and reporting) Head Start enrollees as an ongoing program function.

f. The vast majority of non-Head Start children screened had not been previously enrolled, and most were siblings. Therefore, this finding shows that the projects made a concerted effort to provide services to the families of Head Start children, rather than an unrelated group.

3. Policy Considerations on Receipt of Medical Services Screening

a. More definitive information is needed regarding the content of the screening package in local Head Start projects and the time frame in which children are screened (at admission, during the program, etc.) in order that an evaluation can be made about the consistency and quality of screening services provided. Also, there is need for information about medical problems that may be discovered during the screening and provision for follow-up on these.

b. Head Start projects can better utilize EPSDT services to provide screening if adequate technical assistance is available to aid in accessing Medicaid funds, thereby relieving the Head Start program of paying for all health services.

c. Further, if greater priority is given to ensuring that all children are completely screened as soon as possible, then the likelihood is greater that Medicaid certified children can receive diagnosis and treatment, if needed, as a reimbursable service. Such priority is important because Medicaid eligibility tends to fluctuate over time.

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES-SCREENING BY AGGREGATED TOTALS

Table XVI-A

	A			B			C		
	CHILDREN PARTICIPATING CUMULATIVE			CHILDREN PREVIOUSLY SCREENED			CHILDREN SCREENED DURING PROGRAM YEAR		
	1	2	3	1	2	3	1	2	3
	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS
NATIONAL TOTALS	52,189	38,912	13,277	26,010	22,426	3,584	95,997	82,782	13,215
SELECTED PROJECTS	9,561	5,691	3,870	2,616	2,240	376	7,424	6,883	541
OTHER PROJECTS	42,628	33,221	9,407	23,394	20,186	3,208	88,573	75,899	12,674
REGION: I	4,566	2,444	2,122	2,272	1,565	707	7,189	5,204	1,985
II	4,368	2,636	1,732	2,716	2,198	518	9,418	8,007	1,411
III	2,810	2,416	394	1,931	1,668	263	2,265	1,994	271
IV	9,420	7,373	2,047	5,151	4,466	685	27,122	23,665	3,457
V	7,196	5,194	2,002	3,244	2,890	354	10,462	9,549	913
VI	13,119	12,178	941	7,248	6,889	359	23,103	20,752	2,351
VII	1,893	1,652	241	677	620	57	3,636	3,462	174
VIII	4,674	3,284	1,390	1,539	1,214	325	7,549	6,667	882
IX	694	567	127	158	94	64	1,213	662	551
X	3,449	1,168	2,281	1,074	822	252	4,040	2,820	1,220
*IMPD	1,887	1,139	748	444	355	89	3,736	3,475	261

* Not included in total. Amounts are, however, reflected in various regional totals.

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES-SCREENING BY AGGREGATED TOTALS

Table XVI-A
(Continued)

	D			E		
	CHILDREN COMPLETELY SCREENED DURING PROGRAM YEAR			SCREENING INCOMPLETE FOLLOW-UP REQUIRED		
	1	2	3	1	2	3
	TOTAL	HS	NHS	TOTAL	HS	NHS
NATIONAL TOTALS	30,540	24,884	5,656	65,457	57,898	7,559
SELECTED PROJECTS	5,288	4,890	398	2,137	1,993	144
OTHER PROJECTS	25,252	19,994	5,258	63,320	55,905	7,415
REGION: I	1,586	1,139	447	5,603	4,065	1,538
II	2,067	1,356	711	7,351	6,651	700
III	723	602	121	1,542	1,392	150
IV	8,750	7,028	1,722	18,372	16,637	1,735
V	3,317	3,042	275	7,145	6,507	638
VI	8,674	7,557	1,117	14,429	13,195	1,234
VII	664	568	96	2,972	2,894	78
VIII	2,855	2,477	378	4,694	4,190	504
IX	417	271	146	796	391	405
X	1,487	844	643	2,553	1,976	577
*IMPD	1,449	1,191	258	2,287	2,284	3

* Not included in totals. Amounts are, however, reflected in the various regional totals.

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1

SELECTED PROJECTS BY STATE	A CHILDREN PARTICIPATING CUMULATIVE	
	HS	NHS
TOTALS FOR SELECTED PROJECTS	5,691	3,870
MASSACHUSETTS (I): Leominster	264	71
Worcester	464	279
NEW JERSEY (II): Trenton	282	102
Toms River	129	40
Paterson	190	210
MARYLAND (III): Baltimore	488	137
MISSISSIPPI (IV): Cleveland		
TENNESSEE (IV): Kingston	167	94
ILLINOIS (V): Cooks County	499	407
East St. Louis	458	155
Danville	282	-0-
OHIO (V): Cincinnati		
Dayton		
TEXAS (VI): Lubbock	112	3
Amarillo	896	45
Laredo (IMPD)		
MISSOURI (VII): Springfield	515	106
Appleton		
MONTANA (VIII): Billings	147	20
Fort Peck (IMPD)	344	-0-
Blackfeet (IMPD)	174	450
CALIFORNIA (IX): El Centro		
Fresno (IMPD)		
OREGON (X): Medford	152	1,650
Eugene	128	101

INDICATORS OF EPSDT PERFORMANCE:
MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	B																		
	CHILDREN PREVIOUSLY SCREENED																		
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
								a	b	c		a	b	c		a	b	
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth
TOTALS FOR SELECTED PROJECTS	2,240	376	649	N/A	1,591	N/A	1,363	228	113	-0-	44	2	3	-0-	727	-0-	-0-	-
MASSACHUSETTS (I):																		
Leominster	7	1	-0-	N/A	7	N/A	5	1	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-
Worcester	384	13	3	N/A	381	N/A	263	-0-	12	-0-	6	-0-	-0-	-0-	114	-0-	-0-	-
NEW JERSEY (II):																		
Trenton	117	36	-0-	N/A	117	N/A	90	27	3	-0-	-0-	-0-	-0-	-0-	23	-0-	-0-	-
Toms River	87	-0-	-0-	N/A	87	N/A	62	-0-	-0-	-0-	-0-	-0-	-0-	-0-	24	-0-	-0-	-
Paterson	44	85	18	N/A	26	N/A	43	83	78	-0-	-0-	2	-0-	-0-	-0-	-0-	-0-	
MARYLAND (III):																		
Baltimore	446	86	215	N/A	231	N/A	313	2	77	-0-	-0-	-0-	3	-0-	125	-0-	-0-	
MISSISSIPPI (IV):																		
Cleveland																		
TENNESSEE (IV):																		
Kingston	111	30	28	N/A	83	N/A	32	30	-0-	-0-	2	-0-	-0-	-0-	77	-0-	-0-	-
ILLINOIS (V):																		
Cooks County	321	2	168	N/A	153	N/A	191	2	-0-	-0-	2	-0-	-0-	-0-	123	-0-	-0-	-
East St. Louis	96	1	9	N/A	87	N/A	73	1	-0-	-0-	17	-0-	-0-	-0-	6	-0-	-0-	-
Danville	152	-0-	77	N/A	75	N/A	9	-0-	-0-	-0-	2	-0-	-0-	-0-	55	-0-	-0-	-
OHIO (V):																		
Cincinnati																		
Dayton																		

CODE: N/A = Information not available

INDICATORS OF EPSDT PERFORMANCE:
MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	B																	
	CHILDREN PREVIOUSLY SCREENED																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS	
								a	b	c		a	b	c		a	b
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.
TEXAS (VI): Lubbock	8	-0-	1	N/A	7	N/A	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	8	-0-	-0-
Amarillo	116	-0-	63	N/A	53	N/A	14	-0-	-0-	-0-	12	-0-	-0-	-0-	90	-0-	-0-
Laredo (IMPD)																	
MISSOURI (VII): Springfield	117	5	8	N/A	109	N/A	117	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton																	
MONTANA (VIII): Billings	38	21	5	N/A	33	N/A	25	-0-	10	-0-	-0-	-0-	-0-	-0-	13	-0-	-0-
Fort Peck (IMPD)	-0-	-0-	-0-	N/A	-0-	N/A	-0-			-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	46	-0-	20	N/A	26	N/A	18	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-
CALIFORNIA (IX): El Centro																	
Fresno (IMPD)																	
OREGON (X): Medford	61	14	31	N/A	30	N/A	41	5	5	-0-	-0-	-0-	-0-	-0-	20	-0-	-0-
Eugene	89	82	3	N/A	86	N/A	67	77	1	-0-	3	-0-	-0-	-0-	19	-0-	-0-

CODE: N/A = Iformation not available

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN SCREENED DURING PROGRAM YEAR																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	
TOTALS FOR SELECTED PROJECTS	6,883	541	2,427	41	4,438	500	3,470	336	109	-0-	153	4	6	-0-	3,236	13	3[illegible]	
MASSACHUSETTS (I):																		
Leominster	13	20	-0-	7	13	13	8	4	6	-0-	1	1	4	-0-	4	-0-	[illegible]	-0
Worcester	383	13	3	11	379	2	264	-0-	-0-	-0-	6	-0-	-0-	-0-	112	-0-	-0-	
NEW JERSEY (II):																		
Trenton	22	8	-0-	-0-	22	8	19	4	-0-	-0-	-0-	-0-	-0-	-0-	3	4	-0-	-
Toms River	171	-0-	13	-0-	158	-0-	122	-0-	-0-	-0-	3	-0-	-0-	-0-	45	-0-	-0-	-0
Paterson	61	52	14	-0-	47	52	59	46	4	-0-	-0-	2	-0-	-0-	2	-0-	-0-	-0
MARYLAND (III):																		
Baltimore	421	82	200	-0-	219	82	301	2	74	-0-	-0-	-0-	2	-0-	114	-0-	4	-0
MISSISSIPPI (IV):																		
Cleveland	2,456	252	1,619	1	828	251	1,119	245	1	-0-	39	-0-	-0-	-0-	1,294	-0-	-0-	
TENNESSEE (IV):																		
Kingston	148	2	30	-0-	116	2	36	2	-0-	-0-	2	-0-	-0-	-0-	110	-0-	-0-	-0
ILLINOIS (V):																		
Cooks County	621	2	169	-0-	450	2	379	-0-	-0-	-0-	4	-0-	-0-	-0-	230	-0-	-0-	
East St. Louis	204	8	24	-0-	180	8	157	6	1	-0-	26	-0-	-0-	-0-	20	1	-0-	-0
Danville	305	-0-	88	-0-	217	-0-	186	-0-	-0-	-0-	4	-0-	-0-	-0-	115	-0-	-0-	-0
OHIO (V):																		
Cincinnati																		
Dayton	310	16	1	4	309	12	186	3	5	-0-	-0-	-0-	-0-	-0-	122	5	2	

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	C CHILDREN SCREENED DURING PROGRAM YEAR TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
	HS	NHS	HS	NHS	HS	NHS	HS	Non-HS a Sib.	Non-HS b Non-Sib.	Non-HS c Oth.	HS	Non-HS a Sib.	Non-HS b Non-Sib.	Non-HS c Oth.	HS	Non-HS a Sib.	Non-HS b Non-Sib.	
TEXAS (VI): Lubbock	215	-0-	4	-0-	211	-0-	43	-0-	-0-	-0-	-0-	-0-	-0-	-0-	172	-0-	-0-	
Amarillo	626	6	65	-0-	561	6	51	-0-	1	-0-	45	-0-	-0-	-0-	529	-0-	5	
Laredo (IMPD)		-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
MISSOURI (VII): Springfield	117	1	8	-0-	109	1	117	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
Appleton	160	4	11	1	148	3	71	1	2	-0-	1	1	-0-	-0-	88	-0-	-0-	
MONTANA (VIII): Billings	150	35	7	-0-	143	35	93	1	15	-0-	-0-	-0-	-0-	-0-	57	-0-	18	
Fort Peck (IMPD)	148	-0-	86	-0-	61	-0-	77	-0-	-0-	-0-	1	-0-	-0-	-0-	70	-0-	-0-	
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
CALIFORNIA (IX): El Centro	103	15	21	1	82	14	26	15	-0-	-0-	15	-0-	-0-	-0-	62	-0-	-0-	
Fresno (IMPD)	32	-0-	31	-0-	1	-0-	2	-0-	-0-	-0-	2	-0-	-0-	-0-	28	-0-	-0-	
OREGON (X): Medford	128	25	32	16	96	9	85	6	-0-	-0-	1	-0-	-0-	-0-	42	3	-0-	1
Eugene	89	-0-	1	-0-	88	-0-	69	-0-	-0-	-0-	3	-0-	-0-	-0-	17	-0-	-0-	

INDICATORS OF EPSDT PERFORMANCE: MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	D — CHILDREN COMPLETELY SCREENED DURING PROGRAM YEAR																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)		
								Non-HS				Non-HS				Non-HS	
								a	b	c		a	b	c		a	b
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.
TOTALS FOR SELECTED PROJECTS	4,890	398	1,826	31	3,055	367	2,401	283	48	-0-	117	2	2	-0-	2,357	12	19
MASSACHUSETTS (I):																	
Leominster	12	7	-0-	4	12	3	7	3	2	-0-	1	-0-		-0-	4	-0-	1
Worcester	320	13	[illegible]	11	317	2	219	-0-	-0-	-0-	5	-0-	-0-	-0-	95	-0-	-0-
NEW JERSEY (II):																	
Trenton	18	6	-0-	-0-	18	6	16	3	-0-	-0-	-0-	-0-	-0-	-0-	2	3	-0-
Toms River	162	-0-	13	-0-	149	-0-	116	-0-	-0-	-0-	3	2	-0-	-0-	43	-0-	-0-
Paterson	56	52	13	-0-	43	52	54	46	4	-0-	-0-	-0-	1	-0-	2	-0-	-0-
MARYLAND (III):																	
Baltimore	173	24	85	-0-	86	24	118	-0-	22	-0-	-0-	-0-	-0-	-0-	52	-0-	1
MISSISSIPPI (IV):																	
Cleveland	1,516	225	1,262	1	249	224	710	218	1	-0-	16	-0-	-0-	-0-	789	-0-	-0-
TENNESSEE (IV):																	
Kingston	96	1	24	-0-	72	1	24	1	-0-	-0-	2	-0-	-0-	-0-	70	-0-	-0-
ILLINOIS (V):																	
Cooks County	466	1	131	-0-	335	1	285	-0-	-0-	-0-	2	-0-	-0-	-0-	172	-0-	-0-
East St. Louis	71	1	17	-0-	54	1	43	-0-	1	-0-	24	-0-	-0-	-0-	3	-0-	-0-
Danville	219	-0-	66	-0-	153	-0-	135	-0-	-0-	-0-	1	-0-	-0-	-0-	83	-0-	-0-
OHIO (V):																	
Cincinnati																	
Dayton	294	15	1	4	293	11	177	2	5	-0-	-0-	-0-	-0-	-0-	115	5	2

INDICATORS OF EPSDT PERFORMANCE:
MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Al (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN COMPLETELY SCREENED DURING PROGRAM YEAR																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)		
								Non-HS				Non-HS				Non-	
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.
TEXAS (VI):																	
Lubbock	207	1	4	-0-	203	1	41	-0-	-0-	-0-	-0-	-0-	-0-	-0-	166	1	-0-
Amarillo	626	6	67	-0-	559	6	50	-0-	1	-0-	45	-0-	-0-	-0-	531	-0-	5
Laredo (IMPD)	-0-	0	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII):																	
Springfield	114	1	8	-0-	106	1	114	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	77	1	7	-0-	70	1	36	-0-	1	-0-	-0-	-0-	-0-	-0-	41	-0-	-0-
MONTANA (VIII):																	
Billings	139	22	5	-0-	134	22	86	1	11	-0-	-0-	-0-	-0-	-0-	53	-0-	10
Fort Peck (IMPD)	100	-0-	57	-0-	42	-0-	49	-0-	-0-	-0-	-0-	-0-	-0-	-0-	51	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX):																	
El Centro	37	-0-	8	-0-	29	-0-	7	-0-	-0-	-0-	13	-0-	-0-	-0-	17	-0-	-0-
Fresno (IMPD)	27	-0-	27	-0-	-0-	-0-	2	-0-	-0-	-0-	2	-0-	-0-	-0-	23	-0-	-0-
OREGON (X):																	
Medford	104	22	29	11	75	11	71	8	-0-	-0-	1	-0-	-0-	-0-	32	3	-0-
Eugene	56	-0-	-0-	-0-	56	-0-	41	-0-	-0-	-0-	2	-0-	-0-	-0-	13	-0-	-0-

INDICATORS OF EPSDT PERFORMANCE:
MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-A1 (Cont'd)

SELECTED PROJECTS BY STATE	E SCREENING INCOMPLETE FOLLOW-UP REQUIRED TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
								a	b	c		a	b	c		a	b	
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth
TOTALS FOR SELECTED PROJECTS	1,993	144	603	10	1,381	136	1,068	55	61	-0-	33	2	4	-0-	881	2	14	
MASSACHUSETTS (I):																		
Leominster	1	13	-0-	3	1	10	1	1	4	-0-	-0-	1	3	-0-	-0-	-0-	3	-0
Worcester	63	-0-	1	-0-	62	-0-	45	-0-	-0-	-0-	1	-0-	-0-	-0-	17	-0-	-0-	-0
NEW JERSEY (II):																		
Trenton	4	2	-0-	-0-	4	2	3	1	-0-	-0-	-0-	-0-	-0-	-0-	1	1	-0-	-0
Toms River	9	-0-	-0-	-0-	9	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0
Paterson	5	-0-	1	-0-	4	-0-	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MARYLAND (III):																		
Baltimore	248	58	115	-0-	133	58	183	2	52	-0-	-0-	-0-	1	-0-	62	-0-	3	-0
MISSISSIPPI (IV):																		
Cleveland	940	27	357	-0-	579	27	409	27	-0-	-0-	23	-0-	-0-	-0-	505	-0-	-0-	-0-
TENNESSEE (IV):																		
Kingston	52	1	6	-0-	44	1	12	1	-0-	-0-	-0-	-0-	-0-	-0-	40	-0-	-0-	-0
ILLINOIS (V):																		
Cooks County	155	1	38	-0-	115	1	94	-0-	-0-	-0-	2	-0-	-0-	-0-	58	-0-	-0-	
East St. Louis	133	7	7	-0-	126	7	114	6	-0-	-0-	2	-0-	-0-	-0-	17	1	-0-	-0-
Danville	86	-0-	22	-0-	64	-0-	51	-0-	9	-0-	-0-	-0-	-0-	-0-	32	-0-	-0-	-0-
OHIO (V):																		
Cincinnati																		
Dayton	16	1	-0-	-0-	16	1	9	1	-0-	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	-0-

INDICATORS OF EPSDT PERFORMANCE:
MEDICAL SERVICES - SCREENING OF HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Al (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	SCREENING INCOMPLETE FOLLOW-UP REQUIRED																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c
TEXAS (VI): Lubbock	8	-0-	-0-	-0-	8	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-(
Amarillo	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-(
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-(
MISSOURI (VII): Springfield	3	-0-	-0-	-0-	3	-0-	[illegible]	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-(
Appleton	83	3	4	1	78	2	35	1	1	-0-	1	1	-0-	-0-	47	-0-	-0-	-(
MONTANA (VIII): Billings	11	13	2	-0-	9	13	7	-0-	4	-0-	-0-	-0-	-0-	-0-	4	-0-	8	
Fort Peck (IMPD)	48	-0-	29	-0-	19	-0-	28	-0-	-0-	-0-	1	-0-	-0-	-0-	19	-0-	-0-	-0
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
CALIFORNIA (IX): El Centro	66	15	13	1	53	14	19	15	-0-	-0-	2	-0-	-0-	-0-	45	-0-	-0-	-0
Fresno (IMPD)	5	-0-	4	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
OREGON (X): Medford	24	3	3	5	21	-0-	14	-0-	-0-	-0-	-0-	-0-	-0-	-0-	10	-0-	-0-	
Eugene	33	-0-	1		32		28	-0-	-0-	-0-	1	-0-	-0-	-0-	4	-0-	-0-	-0-

B. MEDICAL SERVICES - DIAGNOSIS AND TREATMENT

Many children once screened needed diagnostic evaluation because evidence of a possible medical problem had been detected. Treatment services were to be prescribed as necessary and obtained as part of the continuity of medical care envisioned in the collaborative effort.

The data presented in Tables XVI-B, and XVI-B_1 describe the extent to which diagnostic and treatment services were actually received during the program year. The information is categorized by current Head Start enrollment nationally. For the selected projects, Table XVI-B_1, the data is further arranged by Head Start enrollment prior to the collaborative effort, Medicaid certification, and sibling relationship to Head Start enrollees.

Definition of Terms

Children Diagnosed/Evaluated refers to the total number of children who received specific diagnostic or evaluative examination by trained medical personnel to determine the presence of a medical problem for which treatment should be prescribed.

Children Treated refers to the total number of children who actually recieved medical treatment by trained medical personnel.

Children Treated by Type of Unit of Service refers to the frequency with which specific treatment services were provided:

- Acute/Chronic refers to treatment services provided for medical problems which were episodic or ongoing in nature but did not require surgical intervention or corrective devices.
- Surgical/Corrective refers to the application of surgical procedures (in or out-patient) or prosthetic devices (eyeglasses, hearing aids, orthopedic appliances) to alleviate a medical problem.
- Other refers to treatment services provided but not covered under the above two categories.

Children Requiring Follow-up refers to those children diagnosed or treated for whom the need for follow-up services had been indicated.

1. Analysis of Findings

Children Diagnosed/Evaluated (B)

Aggregate Totals

There were 9,197 children who received diagnostic or evaluation services during the program year, of which 85% (7,906 out of 9,197) were currently enrolled in Head Start. For the selected projects, 1,890 were reported to have received these services and 94% of these were Head Start children.

No information is available to determine whether the diagnostic services received as a result of the screening. However, if such assumption can be made, then less than 10% of children screened nationally were also diagnosed; and for the selected projects, this percentage rose to 25%. However, caution should be exercised in considering this data since there is no evidence of a sequential relationship between screening and diagnosis.

According to recent hearings before the House Subcommittee on Oversight and Investigation (October, 1975)[1], only 15%

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(1) *Op. cit*

(1.9 million of the 13 million children eligible for EPSDT) had been screened by 1974. Of these, nearly one-half were found to need additional diagnosis and treatment services. Therefore, the Head Start projects appear to be below the national experience in this regard. All regions, except Regions III, VI and VII, which reported much lower percentages at 4%, 7%, and 4% respectively, followed the national pattern in relation to the proportion of children diagnosed compared to those screened.

Selected Projects

Twenty-one projects submitted data regarding the receipt of diagnostic/evaluative services by Head Start children this year.[2] Of the children screened, 26% (1,791 out of 6,882) received diagnostic services. Cleveland accounted for over 50% of this group (975 out of 1,791). Seven projects--Leominster, Trenton, Baltimore, Amarillo, Springfield, and Fort Peck--had less than 10% of their Head Start children diagnosed who had been screened. Three projects, however--Toms River, Lubbock and Medford--were closer to the average for all selected projects.

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(2) East St. Louis did not report any children in this category.

Of the Head Start children diagnosed, 89% had been previously enrolled in the program. The majority of the projects indicated that very few of their diagnosed Head Start children had been in the program previously. On the other hand, Fresno reported all children in this category as previously enrolled, and in Fort Peck, 10 out of 19 were.

Less than half (47%) of the total number of Head Start children who received diagnostic services were Medicaid certified, which means that the cost for these services were most likely borne by the family or by the program itself. Many of the projects individually reported greater proportions of Head Start children as Medicaid certified. For example, three projects--Trenton, Paterson and Springfield--stated that all their Head Start children receiving diagnostic services were Medicaid certified, and eight others indicated that over 70% were in this category.

Only nine projects--Leominster, Worcester, Paterson, Baltimore, Cleveland, Dayton, Appleton, Billings and Medford--reported non-Head Start children being diagnosed, as compared to the 21 projects reporting Head Start children in this category. A total of 99 non-Head Start children were diagnosed among the nine projects, with the highest number (69) being located in Cleveland. Three projects--Baltimore, Appleton, Billings--had one child each and Medford had two.

Of the 99 non-Head Start children, 90% had not been in the program previously. Worcester did state, however, that six out of eight of its non-Head Start children diagnosed had been in the program prior to the collaborative effort. Almost all (94) of the non-Head Start children diagnosed were Medicaid certified.

Children Treated (C)

Aggregate Totals

On the national level, 10,799 children were reported as treated during this year. This represents almost 11% of those screened; but again there is no evidence that such services were rendered as a result of screening or diagnosis. Moreover, there is a greater number of children reported as treated than diagnosed/evaluated. This finding most likely reflects traditional medical practices rather than inaccurate reporting, since medical personnel tend to consider diagnosis and treatment as one service, with the greater emphasis upon treatment, and since both are usually provided at the same time.

Also, it is probable that many children, particularly those with acute symptoms (colds, stomach ailments, fractures, etc.), were referred directly for treatment without an antecedent diagnostic examination. Telephone inquiries to a few projects substantiated that they did, indeed, refer children directly for treatment without screening or diagnosis services being provided, either because the medical problems were acute or because the condition had been diagnosed and/or under treatment prior to the collaborative effort.

Of the children reported as treated, however, 8,802, or 81%, were Head Start enrollees. For the selected projects, 2,103 children were treated, of which over 96% were enrolled in Head Start at that time.

Regionally, there were several areas which exceeded the national rate of screened children who were treated, with Region VII registering the highest at 20%. The next highest were the IMPD projects at 19%. The lowest percentage rate was in Region III (4%).

Selected Projects

In the selected projects, 2,008 Head Start children, or 30% of those screened,were reported in receipt of treatment of services, with 21 projects reporting. Eugene, which had indicated that 15 Head Start children were diagnosed, reported no Head Start children treated. Cleveland's Head Start population (1,324) constituted the majority of the children treated; the next highest was Amarillo with 148.

Over half of the Head Start children were previously enrolled in the program, but most of this group came from the Cleveland project. Most of the projects (16 out of 21) reported that the majority of the Head Start children treated had not been in the program previously.

The majority (56%) of Head Start children treated were, however, either ineligible for Medicaid or their status was unknown. The Cleveland and Amarillo projects accounted for most of these children, but Kingston, Lubbock, Appleton and El Centro also reported more children as Medicaid ineligible or status unknown. Most of the projects reported the majority of their Head Start children as Medicaid certified.

As was the case with diagnostic services received, there were few (95) non-Head Start children reported as treated, and these constituted 17% of the total non-Head Start population screened this year. There was an increase to 13 for the number of projects reporting non-Head Start children in this category compared to those reporting diagnostic services (9). Cleveland again accounted for the majority (58) of the non-Head Start children treated. Leominster was next highest with 9. Most of the non-Head Start children (91 out of 95) had not previously been enrolled in Head Start. The majority of the non-Head Start children (84%) were Medicaid certified and most of these (67) were siblings of Head Start enrolless.

Children Treated by Type of Unit Service (D)

Aggregate Totals

There were 28,655 units of treatment services provided to children nationally during the year, which would suggest that on the average each child treated received 2.6 units of services.

28,655=(treatment units)
= 2.6 (treatment units per child)
10,799=(children treated)

Acute/chronic treatment was by far the most predominant type of service provided at 83% of the total (24,015 out of 28,655). Surgical/corrective treatment was the least prevalent service provided during the year 2,149 units of service. For "other" units 2,491 such services were reported.

Most (84%) of the acute/chronic treatment units, were provided to Head Start children. At the selected project level, an even greater proportion (95%) of these services was given to Head Start children. Region IV had the highest number of acute/chronic services provided: 10,657, or 40% of the national total. The lowest incidence was in Region III, with 261 units reported. Interestingly, Region I provided a greater number of these units to non-Head Start children, 54% or 1,294 out of 2,397 units reported.

The majority (88%) of the surgical/corrective units and "other" treatment units (79%) were also provided to Head Start children. This pattern held true for the selected projects and at the regional level.

Selected Projects

There were 10,189 units of treatment services provided to Head Start children in the selected projects during the year. Using the formula cited above, this means that each Head Start child treated in the selected projects received 5.6 units of service, or double the national rate. Acute/chronic services were again the most prevalent (95%) of the total units provided. Only 730 surgical/corrective units and 182 other were reported for Head Start children. Nineteen projects submitted data in this category. Fresno, while reporting Head Start children, provided no information on units of service.

Cleveland accounted for over two-thirds of the acute/chronic services provided, and Amarillo was next with 639. Trenton reported the least, 15. The majority (59%) of these units went to Head Start children who were previously enrolled in the program. Five projects--Leominster, Worcester, Trenton, Dayton and Lubbock--reported no acute/chronic treatment units provided to previously enrolled Head Start children.

Most (55%) of the acute/chronic units were provided to Head Start children who were either ineligible for Medicaid or whose status was unknown. Most of these were provided to Head Start children in Cleveland, Amarillo, Appleton, Kingston, and Lubbock. The majority of the remaining projects, 13 out of 19, indicated that the greatest proportion of these units went to Medicaid certified Head Start children.

Fifteen projects reported a total of 730 surgical/corrective units of service being given to Head Start children (Leominster, Worcester, Baltimore, and Dayton did not report in this category.)

Over half (54%) of these units went to previously enrolled Head Start children, most of which were in Cleveland. Like acute/chronic services, the majority of surgical/corrective units went to Head Start children reported as Medicaid Other, with Cleveland contributing the largest number to this group (222 out of 361). Nine out of 14 projects provided the majority of these units to Medicaid certified Head Start children.

Eighteen projects reported a total of 182 Other treatment units being received by Head Start children. Eight out of the eighteen projects had no previously enrolled Head Start child receiving Other treatment units. The majority of the children in Cleveland, on the other hand, were previously enrolled in the program. The majority (99 out of 182) of the Other treatment services went to Medicaid certified Head Start children.

A total of 448 units of treatment was provided to non-Head Start children at a rate of 4.7 units per child, slightly lower than the rate for Head Start children but much higher than the national average for all children. Acute/chronic treatment again constituted the major unit with a frequency of 95%. This was comparable to the rate reported for Head Start children. Only two units of surgical/corrective services and nineteen Other treatment units went to non-Head Start children.

Fourteen projects did not report any acute/chronic services being provided to non-Head Start children; and five--Worcester, Cook County, Kingston, Lubbock, and El Centro--had five or fewer children in this group. Nearly all (96%) of the non-Head Start children receiving this kind of treatment had not been in the program previously. A majority (84%) of the non-Head Start children were Medicaid certified, and a preponderant number (333 out of 362) were siblings of Head Start enrollees. Only two projects--Leominster and Appleton--reported acute/chronic units of service being received by non-Medicaid certified children not currently enrolled in Head Start. In this group of 33 children, 18 were siblings of Head Start children. It should also be noted that for these two projects the majority of treatment services went to non-Head Start children.

Appleton was the only project reporting surgical/corrective services being provided to non-Head Start children. These services were provided to Medicaid certified children not previously enrolled in Head Start, and neither was a sibling of a Head Start enrollee.

Five projects--Leominster, Cleveland, Appleton, Billings and Medford--reported a total of nineteen units of Other treatment services for non-Head Start children. Medford was the highest with eight units. Seventeen of the nineteen units were given to non-Head Start children not previously enrolled in the program. The majority of these services went to Medicaid certified children, of which over 78% were reported to be siblings of Head Start children.

Children Requiring Follow-up (E)

Aggregate Totals

Less than half (46% or 9,290 out of the 19,996) of the children diagnosed or treated nationally required follow-up services. The vast majority (89%) were enrolled in Head Start in the selected projects, and 43% of the children diagnosed or treated during the year needed further services. Regionally, there was general adherence to the national pattern except in Region VII, which had a much lower incidence of children needing follow-up (23%), while Region IX reported nearly 60% of its children in this category.

Selected Projects

3,799 Head Start children in twenty-two selected projects reporting received diagnostic or treatment services during this program year as part of the collaborative effort. Of these, 1,813 or 47% required follow-up services. The highest number of children requiring such services occurred in Cleveland (992). The next highest was Danville with 182. Eight projects reported greater proportions of children needing follow-up than the average rate for the selected projects. Medford and Eugene, on the other hand, indicated that most or all of the Head Start children diagnosed or treated did not need follow-up.

Most (64%) of the Head Start children needing follow-up had not been in the program previously. Of the twenty-two projects, five had no previous enrollees among Head Start children needing follow-up. Fort Peck was the only project with a greater proportion of previously enrolled Head Start children among this group. Less than half of the Head Start children (853 out of 1813) were Medicaid certified, although most of the projects reported that over 50% of their Head Start children needing follow-up were certified.

Only 28% (56 out of 194) of the non-Head Start children diagnosed or treated during the year required follow-up services. Of the fourteen projects reporting non-Head Start children diagnosed or treated, five--Baltimore, Cook County, Dayton, Lubbock and El Centro--stated that none of the children needed follow-up.

Fifth out of the 56 non-Head Start children in this group had not been in the program previously. A majority (42 out of 56) were Medicaid certified and siblings of Head Start enrollees (33 out of 56).

2. Conclusions on Receipt of Diagnostic and Treatment Services

a. Few children were diagnosed or treated compared to the number of screenings reported. Data was unavailable on the nature of the screenings or medical findings, so no conclusion can be drawn about the reason for such a low incidence, i.e., whether such data reflects a healthy child population or shortcomings in the health care system.

b. Head Start children constitute an overwhelming majority both of children diagnosed (85%) and treated (815) nationally. This may be attributed to their accessibility to continued health care through their participation in Head Start, since this incidence exceeds the 74% of Head Start children participating in the collaborative effort overall (Table I-Appendix A).

c. Acute/chronic treatment services were by far the prevalent type of service provided to Head Start and non-Head Start children alike. This pattern held true both at the national and at the individual selected projects level.

d. Less than half of the Head Start children in the selected projects receiving diagnostic or treatment services were Medicaid certified. The greater proportion was either ineligible or of unknown status, which may reflect administrative lag. The large number of children in Cleveland tended, however to skew the data pertaining to the behavior of individual selected projects.

e. On the other hand, the majority of non-Head Start children diagnosed or treated were Medicaid certified and siblings of Head Start enrollees. This finding again highlights the need for the participating projects to assign priority to delivering EPSDT reimbursable services to families of Head Start children rather than to the general community.

f. Approximately one half of the Head Start children nationally and in the selected projects required follow-up services. There was a much lower incidence (28%) of such need among non-Head Start children. Again, due to insufficient data no conclusion can be drawn regarding the relative health status of the two groups.

3. Policy Considerations on Receipt of Diagnostic and Treatment of Services

a. The focus on this evaluation study is on the operational effectiveness of the Head Start EPSDT Collaborative Effort; thus data pertaining to the nature and quality of health service provided was not obtained. However, further studies can provide difinitive information on the health status of Head Start enrollees and their siblings, the extent that medical services are provided/obtained, and the quality of such services.

b. Study data indicate that there are no linear relationships between screening, diagnosis and treatment as received by children in the program. Further studies can pinpoint the efficacy of broadscale screening, particularly as a preventive health measure, if there is not adequate provisions for diagnosis and treatment.

c. The prevalence of acute/chronic treatment as a unit of services can serve as an indicator of the kind of medical care arrangement that can be most feasibly provided/obtained by Head Start. Several factors, such as available program resources; availability accessibility to community health services; or provision of EPSDT services. A review of state EPSDT plans can identify areas for policy change that will allow for additional treatment services to assure continuity of care. A first step is enlarging available resources.

Continued Medicaid eligibility can be a critical factor in determining whether children can be ensured continuity of health care, particularly in those instances where there is need for treatment of a medical problem detected during screening. Additional information would greatly assist considerations of policy, since it would be helpful to know how many children actually failed to receive adequate diagnosis or treatment services because their Medicaid eligibility had lapsed.

MEDICAL SERVICES: DIAGNOSIS AND TREATMENT BY AGGREGATED TOTALS

Table XVI-B

	A			B			C		
	CHILDREN PARTICIPATING CUMULATIVE			CHILDREN DIAGNOSED/EVALUATED			CHILDREN TREATED		
	1	2	3	1	2	3	1	2	3
	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS
NATIONAL TOTALS	52,189	38,912	13,277	9,197	7,906	1,291	10,799	8,802	1,997
SELECTED PROJECTS	9,561	5,691	3,870	1,890	1,791	99	2,103	2,008	95
OTHER PROJECTS	42,628	33,221	9,470	7,307	6,115	1,192	8,696	6,794	1,902
REGION: I	4,566	2,444	2,122	729	384	345	1,209	524	685
II	4,368	2,636	1,732	1,052	775	277	1,323	858	465
III	2,810	2,416	394	103	84	19	106	99	7
IV	9,420	7,373	2,047	3,042	2,653	389	3,468	3,081	387
V	7,196	5,194	2,002	1,020	966	54	701	674	27
VI	13,119	12,178	941	1,605	1,565	40	1,897	1,771	126
VII	1,893	1,652	241	178	162	16	792	786	6
VIII	4,674	3,284	1,390	960	925	35	886	714	172
IX	694	567	127	98	94	4	143	113	30
X	3,449	1,168	2,281	410	298	112	274	182	92
*IMPD	1,887	1,139	748	424	390	34	440	376	64

* Not included in totals. Amounts are dispersed throughout regional totals.

Table XVI-B (Continued)

MEDICAL SERVICES: DIAGNOSIS AND TREATMENT BY AGGREGATED TOTALS

	D									E		
	CHILDREN TREATED BY TYPE OF UNITS OF SERVICE									CHILDREN REQUIRING FOLLOW-UP		
	(I) ACUTE/CHRONIC			(II) SURGICAL/CORRECTIVE			(III) OTHER					
	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS
NATIONAL TOTALS	24,015	20,231	3,784	2,149	1,903	246	2,491	1,981	510	9,290	8,355	935
SELECTED PROJECTS	9,704	9,277	427	732	730	2	201	182	19	1,693	1,637	56
OTHER PROJECTS	14,311	10,954	3,357	1,417	1,173	244	2,290	1,799	491	7,421	6,542	879
REGION: I	2,397	1,103	1,294	170	97	73	406	111	295	1,064	757	307
II	2,539	1,724	815	284	230	54	229	162	67	1,019	845	174
III	261	259	2	14	11	3	28	27	1	85	81	4
IV	10,657	9,737	920	643	629	14	248	235	13	2,779	2,501	278
V	1,424	1,382	42	230	223	7	74	55	19	1,209	1,167	42
VI	2,406	2,197	209	278	257	21	1,040	1,029	11	1,408	1,334	74
VII	1,942	1,917	25	141	138	3	11	10	1	229	225	4
VIII	1,579	1,262	317	283	223	60	322	272	50	1,063	1,032	31
IX	318	262	56	16	14	2	6	5	1	143	140	3
X	492	388	104	90	81	9	127	75	52	291	273	18
*IMPD	791	778	13	106	97	9	140	104	36	508	486	22

*Not included in totals. Amounts are dispersed throughout the various regional totals.

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEADSTART AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-B1

SELECTED PROJECTS BY STATE	A CHILDREN PARTICIPATING CUMULATIVE	
	HS	NHS
TOTALS FOR SELECTED PROJECTS	5,691	3,870
MASSACHUSETTS (I): Leominster	264	71
Worcester	464	279
NEW JERSEY (II): Trenton	282	102
Toms River	129	40
Paterson	190	210
MARYLAND (III): Baltimore	488	137
MISSISSIPPI (IV): Cleveland		
TENNESSEE (IV): Kingston	167	94
ILLINOIS (V): Cooks County	499	407
East St. Louis	458	155
Danville	282	-0-
OHIO (V): Cincinnati		
Dayton		
TEXAS (VI): Lubbock	112	3
Amarillo	896	45
Laredo (IMPD)		
MISSOURI (VII): Springfield	515	106
Appleton		
MONTANA (VIII): Billings	147	20
Fort Peck (IMPD)	344	-0-
Blackfeet (IMPD)	174	450
CALIFORNIA (IX): El Centro		
Fresno (IMPD)		
OREGON (X): Medford	152	1,650
Eugene	128	101

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	CHILDREN DIAGNOSED & EVALUATED											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TOTALS FOR SELECTED PROJECTS	1,791	99	874	10	914	89	857	94	10	2	919	2
MASSACHUSETTS (I): Leominster	7	6	-0-	2	7	4	4	3	-0-	2	3	-0-
Worcester	60	8	2	6	58	2	48	7	1	-0-	11	1
NEW JERSEY (II): Trenton	7	-0-	-0-	-0-	7	-0-	7	-0-	-0-	-0-	-0-	-0-
Toms River	45	-0-	4	-0-	41	-0-	28	-0-	-0-	-0-	17	-0-
Paterson	23	7	7	-0-	16	7	23	7	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	37	1	15	-0-	22	1	29	1	-0-	-0-	8	-0-
MISSISSIPPI (IV): Cleveland	975	69	753	-0-	220	69	424	69	1	-0-	549	-0-
TENNESSEE (IV): Kingston	23	-0-	1	-0-	21	-0-	9	-0-	-0-	-0-	14	-0-
ILLINOIS (V): Cook County	78	-0-	27	-0-	51	-0-	39	-0-	2	-0-	35	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	46	-0-	7	-0-	39	-0-	30	-0-	-0-	-0-	16	-0-
OHIO (V): Cincinnati												
Dayton	116	4	-0-	1	116	3	70	3	-0-	-0-	44	1

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	CHILDREN DIAGNOSED & EVALUATED											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TEXAS (VI): Lubbock	101	-0-	2	-0-	99	-0-	18	-0-	-0-	-0-	83	-0-
Amarillo	36	-0-	3	-0-	33	-0-	1	-0-	1	-0-	34	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	16	-0-	1	-0-	15	-0-	16	-0-	-0-	-0-	-0-	-0-
Appleton	64	1	3	1	61	-0-	28	1	-0-	-0-	36	-0-
MONTANA (VIII): Billings	30	1	-0-	-0-	30	1	20	1	-0-	-0-	10	-0-
Fort Peck (IMPD)	19	-0-	10	-0-	9	-0-	9	-0-	-0-	-0-	10	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	5	-0-	1	-0-	4	-0-	3	-0-	1	-0-	1	-0-
Fresno (IMPD)	25	-0-	25	-0-	-0-	-0-	2	-0-	2	-0-	21	-0-
OREGON (X): Medford	63	2	13	-0-	50	2	39	2	1	-0-	23	-0-
Eugene	15	-0-	-0-	-0-	15	-0-	10	-0-	1	-0-	4	-0-

MEDICAL SERVICES
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	C																		
	CHILDREN TREATED																		
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.
TOTALS FOR SELECTED PROJECTS	2,008	95	1,143	3	861	91	912	67	7	6	28	5	2	3	1,064	4	1	2
MASSACHUSETTS (I): Leominster	9	9	-0-	1	9	8	6	1	3	-0-	-0-	1	2	3	3	-0-	1	-0-
Worcester	37	1	-0-	1	37	-0-	25	-0-	-0-	1	-0-	-0-	-0-	-0-	12	-0-	-0-	-0-
NEW JERSEY (II): Trenton	4	2	-0-	-0-	4	2	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	2	-0-	-0-
Toms River	56	-0-	3	-0-	53	-0-	41	-0-	-0-	-0-	1	-0-	-0-	-0-	14	-0-	-0-	-0-
Paterson	34	4	6	-0-	28	4	32	3	-0-	1	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
MARYLAND (III): Baltimore	50	2	33	-0-	17	2	42	-0-	2	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	1,324	58	1,020	-0-	301	57	581	55	-0-	2	5	1	-0-	-0-	737	-0-	-0-	-0-
TENNESSEE (IV): Kingston	45	2	6	-0-	38	2	10	2	-0-	-0-	-0-	-0-	-0-	-0-	35	-0-	-0-	-0-
ILLINOIS (V): Cooks County	59	1	20	-0-	39	1	33	-0-	-0-	1	2	-0-	-0-	-0-	22	-0-	-0-	-0-
East St. Louis	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Danville	20	-0-	7	-0-	13	-0-	13	-0-	-0-	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	14	-0-	-0-	-0-	14	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVI-B1 (Cont'd)

SELECTED PROJECTS BY STATE	C CHILDREN TREATED: TOTAL (1) HS	TOTAL (1) NHS	PREVIOUSLY ENROLLED (2) HS	PREVIOUSLY ENROLLED (2) NHS	NOT PREVIOUSLY ENROLLED (3) HS	NOT PREVIOUSLY ENROLLED (3) NHS	MEDICAID CERTIFIED (4) HS	MEDICAID CERTIFIED (4) Non-HS a Sib.	MEDICAID CERTIFIED (4) Non-HS b Non-Sib.	MEDICAID CERTIFIED (4) Non-HS c Oth.	NOT MEDICAID CERTIFIED (5) HS	NOT MEDICAID CERTIFIED (5) Non-HS a Sib.	NOT MEDICAID CERTIFIED (5) Non-HS b Non-Sib.	NOT MEDICAID CERTIFIED (5) Non-HS c Oth.	OTHER (6) HS	OTHER (6) Non-HS a Sib.	OTHER (6) Non-HS b Non-Sib.	OTHER (6) Non-HS c Oth.
TEXAS (VI):																		
Lubbock	24	1	-0-	-0-	24	1	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	20	1	-0-	-0-
Amarillo	148	-0-	10	-0-	138	-0-	18	-0-	-0-	-0-	13	-0-	-0-	-0-	117	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII):																		
Springfield	12	-0-	1	-0-	11	-0-	12	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	50	4	2	-0-	48	4	18	-0-	2	-0-	1	2	-0-	-0-	31	-0-	-0-	-0-
MONTANA (VIII):																		
Billings	33	2	1	-0-	32	2	22	-0-	-0-	-0-	-0-	1	-0-	-0-	11	-0-	-0-	1
Fort Peck (IMPD)	11	-0-	9	-0-	2	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX):																		
El Centro	27	2	6	-0-	21	2	7	2	-0-	-0-	6	-0-	-0-	-0-	14	-0-	-0-	-0-
Fresno (IMPD)	6	-0-	5	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
OREGON (X):																		
Medford	43	7	14	1	29	6	28	4	-0-	1	-0-	-0-	-0-	-0-	15	1	-0-	1
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (ACUTE/CHRONIC)																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
								a	b	c		a	b	c		a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	9,277	427	5,511	13	3,747	414	4,169	333	28	1	121	18	5	-0-	4,972	17	-0-	20
MASSACHUSETTS (I):																		
Leominster	37	37	-0-	2	37	35	24	5	12	-0-	-0-	6	5	-0-	13	-0-	-0-	4
Worcester	111	5	-0-	5	111	-0-	80	-0-	-0-	-0-	-0-	-0-	-0-	-0-	31	-0-	-0-	5
NEW JERSEY (II):																		
Trenton	15	-0-	-0-	-0-	15	-0-	10	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
Toms River	260	-0-	15	-0-	245	-0-	189	-0-	-0-	-0-	5	-0-	-0-	-0-	66	-0-	-0-	-0-
Paterson	95	18	24	-0-	71	18	90	18	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
MARYLAND (III):																		
Baltimore	214	-0-	154	-0-	60	-0-	186	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-	-0-
MISSISSIPPI (IV):																		
Cleveland	6,542	287	5,023	-0-	1,504	287	2,881	277	5	-0-	20	-0-	-0-	-0-	3,636	-0-	-0-	5
TENNESSEE (IV):																		
Kingston	184	4	24	-0-	156	4	24	4	-0-	-0-	-0-	-0-	-0-	-0-	160	-0-	-0-	-0-
ILLINOIS (V):																		
Cooks County	222	1	76	-0-	146	1	115	-0-	-0-	1	11	-0-	-0-	-0-	86	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	41	-0-	14	-0-	27	-0-	31	-0-	-0-	-0-	-0-	-0-	-0-	-0-	10	-0-	-0-	-0-
OHIO (V):																		
Cincinnati																		
Dayton	47	-0-	-0-	-0-	47	-0-	33	-0-	-0-	-0-	-0-	-0-	-0-	-0-	14	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	D CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (ACUTE/CHRONIC)																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.
TEXAS (VI):																		
Lubbock	113	5	-0-	-0-	113	5	20	-0-	-0-	-0-	-0-	-0-	-0-	-0-	93	5	-0-	-0-
Amarillo	639	-0-	41	-0-	598	-0-	89	-0-	-0-	-0-	52	-0-	-0-	-0-	498	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII):																		
Springfield	56	-0-	3	-0-	53	-0-	56	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	245	23	10	-0-	235	23	91	-0-	11	-0-	5	12	-0-	-0-	149	-0-	-0-	-0-
MONTANA (VIII):																		
Billings	89	-0-	5	-0-	84	-0-	60	-0-	-0-	-0-	-0-	-0-	-0-	-0-	29	-0-	-0-	-0-
Fort Peck (IMPD)	34	-0-	31	-0-	3	-0-	29	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX):																		
El Centro	132	5	30	-0-	102	5	34	5	-0-	-0-	28	-0-	-0-	-0-	70	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X):																		
Medford	201	42	61	6	140	36	127	24	-0-	-0-	-0-	-0-	-0-	-0-	74	12	-0-	6
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	D																		
	CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (SURGICAL/CORRECTIVE)																		
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)				
								Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	730	2	396	-0-	334	2	357	-0-	2	-0-	7	-0-	-0-	-0-	366	-0-	-0-	-0-
MASSACHUSETTS (I): Leominster	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Worcester	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
NEW JERSEY (II): Trenton	8	-0-	-0-	-0-	8	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Toms River	34	-0-	-0-	-0-	34	-0-	28	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
Paterson	27	-0-	13	-0-	14	-0-	23	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
MARYLAND (III): Baltimore	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	399	-0-	363	-0-	36	-0-	177	-0-	-0-	-0-	-0-	-0-	-0-	-0-	222	-0-	-0-	-0-
TENNESSEE (IV): Kingston	38	-0-	-0-	-0-	38	-0-	18	-0-	-0-	-0-	-0-	-0-	-0-	-0-	20	-0-	-0-	-0-
ILLINOIS (V): Cooks County	11	-0-	2	-0-	9	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	10	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	21	-0-	9	-0-	12	-0-	16	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVl-Bl (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (SIRGICAL/CORRECTIVE)																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
								a	b	c		a	b	c		a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	30	-0-	-0-	-0-	30	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	26	-0-	-0-	-0-
Amarillo	51	-0-	-0-	-0-	51	-0-	6	-0-	-0-	-0-	7	-0-	-0-	-0-	38	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	8	-0-	-0-	-0-	8	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	12	2	-0-	-0-	12	2	8	-0-	2	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
MONTANA (VIII): Billings	41	-0-	-0-	-0-	41	-0-	22	-0-	-0-	-0-	-0-	-0-	-0-	-0-	19	-0-	-0-	-0-
Fort Peck (IMPD)	2	-0-	-0-	-0-	2	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	4	-0-	-0-	-0-	4	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	44	-0-	9	-0-	35	-0-	32	-0-	-0-	-0-	-0-	-0-	-0-	-0-	12	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-B1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (OTHER)																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	b	c		Non-HS a	b	c		Non-HS a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	182	19	73	2	109	17	105	11	3	-0-	1	1	-0-	-0-	76	2	-0-	2
MASSACHUSETTS (I): Leominster	3	4	-0-	1	3	3	3				-0-				-0-			
Worcester	8	-0-	-0-	-0-	8	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
NEW JERSEY (II): Trenton	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Toms River	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	13	-0-	2	-0-	11	-0-	12	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
MARYLAND (III): Baltimore	5	-0-	4	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	77	5	54	-0-	23	5	42	5	-0-	-0-	-0-	-0-	-0-	-0-	35	-0-	-0-	-0-
TENNESSEE (IV): Kingston	5	-0-	1	-0-	4	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
ILLINOIS (V): Cooks County	4	-0-	2	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	7	-0-	-0-	-0-	7	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	2	-0-	-0-	-0-	2	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	D CHILDREN TREATED BY TYPE OF UNIT OF SERVICE (OTHER)																		
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
								a	b	c		a	b	c		a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	3	-0-	-0-	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
Amarillo	14	-0-	1	-0-	13	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	12	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	4	-0-	-0-	-0-	4	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-
MONTANA (VIII): Billings	5	1	-0-	-0-	5	1	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	1
Fort Peck (IMPD)	2	-0-	2	-0-	-0-	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	26	8	7	1	19	7	14	5	-0-	-0-	-0-	-0-	-0-	-0-	12	2	-0-	1
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVl-Bl (Cont'd)

SELECTED PROJECTS BY STATE	E																			
	CHILDREN REQUIRING FOLLOW-UP																			
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER					
								Non-HS				Non-HS				Non-HS				
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.		
TOTALS FOR SELECTED PROJECTS	1,813	56	608	6	1,199	50	853	33	6	3	37	3	3	-0-	919	2	4	1		
MASSACHUSETTS (I): Leominster	7	14	-0-	2	7	12	4	1	4	-0-	1	1	3	-0-	2	-0-	4	-0-		
Worcester	17	3	-0-	3	17	-0-	12	-0-	-0-	3	1	-0-	-0-	-0-	4	-0-	-0-	-0-		
NEW JERSEY (II): Trenton	8	2	-0-	-0-	8	2	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	2	-0-	-0-		
Toms River	73	-0-	1	-0-	72	-0-	49	-0-	-0-	-0-	-0-	-0-	-0-	-0-	23	-0-	-0-	-0-		
Paterson	25	8	5	-0-	20	8	24	8	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-		
MARYLAND (III): Baltimore	36	-0-	18	-0-	18	-0-	27	-0-	-0-	-0-	-0-	-0-	-0-	-0-	8	-0-	-0-	-0-		
MISSISSIPPI (IV): Cleveland	992	18	438	-0-	550	18	441	18	-0-	-0-	22	-0-	-0-	-0-	527	-0-	-0-	-0-		
TENNESSEE (IV): Kingston	145	2	29	-0-	114	2	35	2	-0-	-0-	2	-0-	-0-	-0-	108	-0	-0-	-0-		
ILLINOIS (V): Cooks County	35	-0-	11	-0-	24	-0-	20	-0-	-0-	-0-	-0-	-0-	-0-	-0-	15	-0-	-0-	-0-		
East St. Lou[illegible]	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-		
Danville	182	-0-	37	-0-	145	-0-	117	-0-	-0-	-0-	4	-0-	-0-	-0-	61	-0-	-0-	-0-		
OHIO (V): Cincinnati																				
Dayton	9	-0-	-0-	-0-	9	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-		

MEDICAL SERVICES:
DIAGNOSIS AND TREATMENT FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XV1-B1 (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CHILDREN REQUIRING FOLLOW-UP																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	21	-0-	-0-	-0-	21	-0-	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	16	-0-	-0-	-0-
Amarillo	69	-0-	6	-0-	63	-0-	5	-0-	-0-	-0-	4	-0-	-0-	-0-	60	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	49	4	4	1	45	3	26	1	2	-0-	-0-	1	-0-	-0-	23	-0-	-0-	-0-
MONTANA (VIII): Billings	17	2	1	-0-	16	2	11	-0-	-0-	-0-	-0-	1	-0-	-0-	6	-0-	-0-	1
Fort Peck (IMPD)	14	-0-	9	-0-	5	-0-	8	-0-	-0-	-0-	1	-0-	-0-	-0-	5	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	31	-0-	25	-0-	6	-0-	9	-0-	-0-	-0-	2	-0-	-0-	-0-	20	-0-	-0-	-0-
Fresno (IMPD)	6	-0-	5	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
OREGON (X): Medford	73	3	18	-0-	55	3	45	3	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

C. RECEIPT OF DENTAL SERVICES

1. Analysis of Findings

Children Receiving Dental Services (C)

Aggregate Totals

Nationally, 48,897 children were reported to have received dental services during this year. This total represents a four-fold increase over those reported to have received such services prior to the collaborative effort (See Table V in the Appendix.) The Head Start projects undoubtedly made a major effort to ensure that children involved in the program obtained dental care. This concentrated effort can be attributed primarily to two factors: compliance with Head Start Performance Standards, and a heightened sensitivity to obtaining health services for children, which the projects viewed as the major objective of the collaborative effort.

Of the total group of children receiving dental services, 87%, or 42,365, were Head Start enrollees. For the selected projects, there was an even greater (five-fold) increase (6533 this year, from 1253 previously) of children receiving dental services. Of these, 93% were in the Head Start program at that time.

At the regional level, the greatest increases from the previous reporting period occurred in Regions I, IV, & V with ratios of seven to one, six to one, and six to one, respectively. In Region III, on the other hand, there was a 19% decrease from the previous year in the number of children receiving dental services.

Selected Projects

Twenty-two projects reported a total of 6,167 Head Start children receiving dental services this year. As noted above, this is a five-fold increase from the previous year (nineteen projects reporting at that time). Cleveland again had the highest number of children (2,284, and Amarillo was next with 609.

The majority (627) of the Head Start children receiving dental services had not been previously enrolled in the program. Two projects--Trenton and Eugene--indicated that none of their Head Start children were previously enrolled, while three projects--Baltimore, Cleveland and Fort Peck--reported that the majority of children had been enrolled in Head Start prior to the collaborative effort.

One half (50%) of the Head Start children were Medicaid certified, but an almost equal number were either ineligible for

Medicaid or of unknown status. Fifteen projects reported a majority of the Head Start children receiving dental services as Medicaid certified, with Springfield stating that all its children were certified (in Paterson, all but one was certified). Seven projects had a majority of their Head Start children recorded as Other, with Fresno indicating that all of its children were in this category. Most of the 130 Head Start children not Medicaid certified came from Cleveland and Amarillo.

Sixteen projects reported a total of 366 non-Head Start children receiveing dental services. This represents about twice as many as reported previously (nine projects reporting at that time), but the gain is not as great when compared to the increase for Head Start children or the national average. The highest number of non-Head Start children in this category were accounted for in Cleveland (225), while Cook County and East St. Louis were the lowest with two each.

Of the 16 projects reporting, eight stated that none of their non-Head Start children had been in the program previously. In fact, no previously enrolled children were included among the vast majority of non-Head Start children receiving dental services (339 out of 366).

About 90% of the non-Head Start children in this category were Medicaid certified, and the majority of these (280 out of 328) were siblings of Head Start enrollees. Seven projects reported that all non-Head Start children receiving dental services were Medicaid certified and the majority or all of them were siblings. In the case of Baltimore, however, all of its Medicaid certified non-Head Start children were not siblings.

Children Treated By Types of Units of Service (D)

Aggregate Totals

The projects were asked to indicate the frequency by which children participating in the Collaborative Effort received dental assessment, i.e., formal screening as preventive care, and treatment services. Nationally, the total units of dental services provided were 53,683, of which assessment constituted the greater proportion, 56%. However for the selected projects, the total units provided were 15,073, of which 56% were treatment services. There is no information to account for this difference except the probability that the selected projects may have placed special priority on obtaining treatment services under the assumption that these had greater health significance. All the regions except Region IX reported that the number of assessment services provided exceeded treatment, but in three -- Regions IV, VII; and IX -- the margin was minimal.

The number of dental service units provided per child is not as great compared to the medical services average. Nationally, each child received a little over one unit of dental services and in the selected projects the rate increased to 2.3, again reflecting more concentrated activity by the projects.

Head Start children received the vast majority, (89) of the assessment services provided nationally. The largest number of units given in a region occurred in Region IV with 9,375 units reported (33% of the national total), but Region III had the greatest proportion of assessment units being provided to Head Start children (1,060 out of 1,066). Region X meanwhile provided more dental assessment services to non-Head Start children.

For dental treatment services, Head Start children again received the greater proportion (89% of the units provided). Region IV again reported the largest number of units provided, 9,026 or 40% of the total 22,156, while Region III had the largest number of units relative to Head Start children. Five other regions--I, V, VII, IX and the IMPD projects--also indicated that the overwhelming majority of dental treatment services went to Head Start children. Region X again had the greater proportion of these services being provided to non-Head Start children.

Selected Projects

The twenty-two projects reporting stated that a total of 14,066 units of dental services were provided during the year to Head Start children at a rate of 2.3 per child. For the total group of children, treatment services were more prevalent. However, nine projects did report a greater proportion of dental *assessment*, rather than *treatment* services, being provided to Head Start children.

Of the 6,117 dental *assessment* services provided, 62% (3,853) went to Head Start children not previously enrolled in the program. Three projects--Leominster, Trenton, and Eugene--reported that none of their Head Start children were previous enrollees. Four others, however--Baltimore, Cleveland, Fort Peck and Fresno--repored previous enrollees in the majority.

One half (50%) of the Head Start children receiving dental *assessment* were Medicaid certified, and the rest (2,960 out of 6,117) were primarily Medicaid *Other*. Four projects--Trenton, Paterson, East St. Louis, and Springfield--had 80% or more of their Head Start children listed as Medicaid certified. Lubbock, Cleveland, Kingston and Amarillo had Medicaid *Other* in the majority.

Cleveland had the largest number of dental treatment services provided (3,692 out of 7,949). Amarillo was next with 589. The majority of these services were provided to children not previously enrolled in Head Start. However, in Cleveland, 76% of the children in this category were previously enrolled.

Less than half (49%) of the dental treatment services went to Medicaid certified Head Start children. In two projects--Paterson, and Springfield--all of the Head Start children receiving dental treatment services were Medicaid certified. On the other hand, five projects--Cleveland, Kingston, Lubbock, Amarillo and El Centro--indicated that a greater number of the Head Start children were either ineligible for Medicaid or of unknown status.

Non-Head Start children were provided with 1,007 units of dental services (with a total of sixteen projects reporting), for a rate of 2.1 per child. Treatment, as in the case of Head Start children, was again the most predominant service provided. But for non-Head Start children, the percentage rate was higher at 70% than that reported for Head Start enrollees.

Of the 364 dental assessment services provided, 93% were given to non-Head Start children not previously enrolled in the program. Sixteen projects reported dental assessment provided and nine of them stated that none of the non-Head Start children receiving such services were previous enrollees. Worcester and Medford did, however, have a greater number of these children previously enrolled.

A great majority (86%) of the dental assessment services went to Medicaid certified non-Head Start children, and the majority of these were siblings of Head Start children. Most of the non-siblings were also Medicaid certified, but the majority of non-Head Start who were Medicaid Other either had no kinship relationship to Head Start children or were of unknown familial relationship.

Eleven projects reported a total of 643 dental treatment services provided, of which 94% went to non-Head Start children not previously enrolled. Seven projects stated that none of the non-Head Start children in receipt of dental treatment were previous enrollees.

Most of the dental treatment services were provided to non-Head Start children who were Medicaid certified (603 out of 643). More than three-fourths of these (79%) were siblings of Head Start enrollees. Cleveland accounted for 455 of the Medicaid certified non-Head Start children, of which 451 were siblings.

Cases Completed (E)

Aggregate Totals

Only 40% of the children receiving dental services (20,042 out of 48,897) had completed services. Of these, 90% or 18,104 were Head Start children. For the selected projects, a much greater proportion of cases (91% or 5948 out of 6533) was reported as completed. Two regions had rates of completion which far exceeded the national average--Region III with 89% and Region IX with 60%. Two other regions had relatively low percentages of completed cases--Region I, 26%, and the IMPD projects, 37%. All regions reported that most of the completed cases represented Head Start children.

Selected Projects

All 22 projects reported cases of dental services completed, for a total rate of 90%, or 5591 out of the 6167 Head Start children receiving such services. Of these, 38% or 2156 of the children were previously enrolled in Head Start (Cleveland accounted, for 1,597 of this group). Twenty-one of the 22 projects, however, had as a majority Head Start children who were not previously enrolled, and in three-Leominster, Trenton and Eugene-none were previously enrolled.

Less than half, (49%) of the cases completed were of Medicaid certified Head Start children. However, 15 projects reported a majority of the children as Medicaid certified. Amarillo and Fresno, however, had a greater number of Medicaid Other.

Almost all the non-Head Start children receiving dental services (357 out of 366) had completed cases comparable to the experience of Head Start children. For the completed group, a majority (328) were not previous enrollees. Eight projects, however, reported a majority of previous enrollees. Again, a major portion (87%) of the non-Head Start children with completed cases were Medicaid certified and the majority of these were siblings (272). Baltimore had the greatest number of non-siblings not part of the Head Start program and they were Medicaid certified.

Cases Requiring Follow-Up (F)

Aggregate Totals

The majority of dental services cases required follow-up: 59% or 28,908 out of 48,897. Of these, 83% were Head Start children. For the selected projects, 9%, or 638 out of 6,533 children receiving dental services needed further assistance. Three regions exceeded the national average--Region I at 73%; Region II at 67%;

and Region VIII at 60%. Region III, on the other hand, listed only 10% of its total children receiving dental services as being in need of follow-up.

Selected Projects

Few of the Head Start children, 10%, or 613 out of 6,167, receiving dental services in the selected projects needed follow-up. The largest number of Head Start children reported in this category occurred in Dayton (176), with the next highest being Fort Peck (122). Interestingly, Cleveland, which had the highest number of Head Start children treated (2,284), stated that none needed follow-up.

Four out of five children needing follow-up had not been previously enrolled in Head Start. This pattern held true for all projects except Baltimore and Fort Peck, where the majority of Head Start children who needed follow-up were previous enrollees. Approximately 60% of the Head Start children who needed further services were Medicaid certified. In Cook County, Billings and Fort Peck, the number of Head Start children Medicaid certified and the number of Medicaid Other were almost equally divided

Some projects reported a total of 25 non-Head Start children needing follow-up. This was less than 1% of the total number of such children receiving dental services. Of this group, 20 were not previously enrolled and 17 out of 25 were Medicaid certified. The projects reporting in this category were Trenton, Paterson, Kingston, East St. Louis, Dayton, Appleton and Eugene.

2. Conclusions on Receipt of Dental Services:

- Head Start projects were markedly successful in obtaining dental services for children participating in the collaborative effort, this year, as evidenced by the fourfold increase from the period just prior to the program. The selected projects and all regions except Region III had increases conparable or better than the national average. The increase was not as dramatic for non-Head Start children, however. Again, it is clear that the projects made an intensive effort to provide dental services for participating children even if they had to pay for the services out of Head Start funds.

- Dental assessment rather than treatment tended to be the type of service provided more frequently, although the situation was reversed in the selected projects for both Head Start and non-Head Start children. The selected projects undoubtedly concentrated their activities on providing treatment, which they may have perceived as a better way of meeting the requirements both of the Performance Standards and the EPSDT Collaborative Effort.

- Less than half of the children receiving dental services nationally had their cases completed, while in the selected projects the overwhelming majority of dental cases for Head Start and non-Head Start children were completed. The experience of selected projects most likely reflects the impact of the collaborative effort on the projects. Because of their selective status these projects were aware of being under intensive review. Since individual child data was being compiled they had greater sensitivity to the need for expediting health care for participating children.

- The majority of Head Start children receiving dental services, including assessment and treatment, were either ineligible for Medicaid or of unknown status while non-Head Start children were primarily Medicaid certified. As noted in similar instances, this data may reflect delay by the projects in securing certification for Head Start children and may also indicate a concentration on providing services to the siblings of Medicaid certified Head Start families.

Table XVI-C

DENTAL SERVICES BY AGGREGATED TOTALS

	A			B			C		
	CHILDREN PARTICIPATING CUMULATIVE			CHILDREN RECEIVING PREVIOUS DENTAL CARE			CHILDREN RECEIVING DENTAL SERVICES		
	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS
NATIONAL TOTALS	52,189	38,912	13,277	12,537	11,243	1,294	48,897	42,365	6,532
SELECTED PROJECTS	9,561	5,691	3,870	1,253	1,066	187	6,533	6,167	366
OTHER PROJECTS	42,628	33,221	9,407	11,284	10,177	1,107	42,364	36,198	6,166
REGION: I	4,566	2,444	2,122	589	444	145	3,535	2,232	1,303
II	4,368	2,636	1,732	970	772	198	4,741	3,584	1,157
III	2,810	2,416	394	823	744	79	670	580	90
IV	9,420	7,373	2,047	2,556	2,292	264	13,959	12,128	1,831
V	7,196	5,194	2,002	1,242	1,059	183	6,640	6,160	300
VI	13,119	12,178	941	4,101	3,964	137	11,234	10,483	751
VII	1,893	1,652	241	477	460	17	2,090	2,082	8
VIII	4,674	3,284	1,390	1,223	1,053	170	3,807	3,316	491
IX	694	567	127	84	74	10	441	386	55
X	3,449	1,168	2,281	472	381	91	1,960	1,414	546
*IMPD	1,887	1,139	748	388	360	28	2,368	2,183	185

* Not included in totals. Amounts are dispersed throughout the various regional totals.

Table XVI-C (Continued)

DENTAL SERVICES BY AGGREGATED TOTALS

	D						E			F		
	CHILDREN TREATED BY TYPES OF UNITS OF SERVICE						CASES COMPLETED			CASES REQUIRING FOLLOW-UP		
	(I) ASSESSMENT			(II) TREATMENT								
	1	2	3	1	2	3	1	2	3	1	2	3
	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS
NATIONAL TOTALS	31,102	27,873	3,229	22,581	20,301	2,280	20,042	18,104	1,938	28,855	24,261	4,594
SELECTED PROJECTS	6,481	6,117	364	8,592	7,949	643	5,948	5,591	357	585	576	9
OTHER PROJECTS	24,621	21,756	2,865	13,989	12,352	1,637	14,094	12,513	1,581	28,270	23,685	4,535
REGION: I	1,651	1,435	216	922	881	41	928	761	167	2,607	1,471	1,136
II	2,818	2,569	249	1,409	1,298	111	1,565	1,449	116	3,167	2,135	1,041
III	581	512	69	327	323	4	601	543	58	69	37	32
IV	9,375	8,112	1,263	9,026	7,885	1,141	6,188	5,417	771	7,771	6,611	1,060
V	4,337	4,084	253	2,107	2,048	59	2,494	2,424	71	3,966	3,736	229
VI	7,612	7,031	581	4,486	4,114	372	4,573	4,292	281	6,661	6,191	470
VII	1,066	1,060	6	1,003	994	9	883	878	5	1,207	1,204	3
VIII	2,121	1,916	205	1,450	1,312	138	1,489	1,297	192	2,318	2,019	299
IX	243	223	20	218	192	26	268	248	20	173	138	35
X	1,298	931	367	1,533	1,254	279	1,053	796	257	907	618	289
*IMPD	1,230	1,179	51	808	781	27	886	838	48	1,482	1,345	137

* Not included in totals. Amounts are dispersed throughout the various regional totals.

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1

SELECTED PROJECTS BY STATE	A CHILDREN PARTICIPATING CUMULATIVE	
	HS	NHS
TOTALS FOR SELECTED PROJECTS	5,691	3,870
MASSACHUSETTS (I):		
Leominster	264	71
Worcester	464	279
NEW JERSEY (II):		
Trenton	282	102
Toms River	129	40
Paterson	190	210
MARYLAND (III):		
Baltimore	488	137
MISSISSIPPI (IV):		
Cleveland		
TENNESSEE (IV):		
Kingston	167	94
ILLINOIS (V):		
Cooks County	499	407
East St. Louis	458	155
Danville	282	-0-
OHIO (V):		
Cincinnati		
Dayton		
TEXAS (VI):		
Lubbock	112	3
Amarillo	896	45
Laredo (IMPD)		
MISSOURI (VII):		
Springfield	515	106
Appleton		
MONTANA (VIII):		
Billings	147	20
Fort Peck (IMPD)	344	-0-
Blackfeet (IMPD)	174	450
CALIFORNIA (IX):		
El Centro		
Fresno (IMPD)		
OREGON (X):		
Medford	152	1,650
Eugene	128	101

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	CHILDREN RECEIVING PREVIOUS DENTAL CARE											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TOTALS FOR SELECTED PROJECTS	1,066	187	N/A	N/A	N/A	N/A	659	175	13	2	394	6
MASSACHUSETTS (I): Leominster	4	-0-	N/A	N/A	N/A	N/A	2	-0-	-0-	-0-	2	-0-
Worcester	59	2	N/A	N/A	N/A	N/A	26	2	1	-0-	32	2
NEW JERSEY (II): Trenton	5	-0-	N/A	N/A	N/A	N/A	4	-0-	-0-	-0-	1	-0-
Toms River	2	-0-	N/A	N/A	N/A	N/A	2	-0-	-0-	-0-	-0-	-0-
Paterson	3	68	N/A	N/A	N/A	N/A	3	66	-0-	2	-0-	-0-
MARYLAND (III): Baltimore	183	18	N/A	N/A	N/A	N/A	126	17	-0-	-0-	57	-0-
MISSISSIPPI (IV): Cleveland												
TENNESSEE (IV): Kingston	91	28	N/A	N/A	N/A	N/A	29	28	1	-0-	61	-0-
ILLINOIS (V): Cook County	195	-0-	N/A	N/A	N/A	N/A	115	-0-	-0-	-0-	80	-0-
East St. Louis	22	-0-	N/A	N/A	N/A	N/A	20	-0-	-0-	-0-	2	-0-
Danville	57	-0-	N/A	N/A	N/A	N/A	40	-0-	-0-	-0-	17	-0-
OHIO (V): Cincinnati												
Dayton												

N/A = Information Not Available

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1 (Cont'd)

SELECTED PROJECTS BY STATE	B CHILDREN RECEIVING PREVIOUS DENTAL CARE TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TEXAS (VI): Lubbock	2	-0-	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	2	-0-
Amarillo	65	-0-	N/A	N/A	N/A	N/A	10	-0-	9	-0-	46	-0-
Laredo (IMPD)												
MISSOURI (VII): Springfield	118	4	N/A	N/A	N/A	N/A	118	4	-0-	-0-	-0-	-0-
Appleton												
MONTANA (VIII): Billings	48	3	N/A	N/A	N/A	N/A	28	3	0	-0-	20	-0-
Fort Peck (IMPD)	122	-0-	N/A	N/A	N/A	N/A	74	-0-	1	-0-	47	-0-
Blackfeet (IMPD)	10	-0-	N/A	N/A	N/A	N/A	6	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro												
Fresno (IMPD)												
OREGON (X): Medford	48	7	N/A	N/A	N/A	N/A	31	4	1	-0-	11	4
Eugene	32	57	N/A	N/A	N/A	N/A	25	53	-0-	-0-	7	-0-

N/A = Information Not Available

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN RECEIVING DENTAL SERVICES DURING PROGRAM YEAR																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	b	c		Non-HS a	b	c		Non-HS a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	6,167	366	2,264	27	3,888	339	3,043	280	34	14	133	-0-	2	-0-	2,975	10	15	9
ASSACHUSETTS (I):																		
Leominster	10	3	-0-	2	10	1	6	1	-0-	-0-	1	-0-	1	-0-	3	-0-	1	-0-
Worcester	369	7	3	7	365	-0-	256	-0-	-0-	7	6	-0-	-0-	-0-	106	-0-	-0-	-0-
NEW JERSEY (II):																		
Trenton	24	8	-0-	-0-	24	8	20	4	-0-	-0-	-0-	-0-	-0-	-0-	4	4	-0-	-0-
Toms River	161	-0-	11	-0-	150	-0-	115	-0-	-0-	-0-	3	-0-	-0-	-0-	43	-0-	-0-	-0-
Paterson	63	5	13	-0-	50	5	62	5	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
ARYLAND (III):																		
Baltimore	211	25	130	-0-	80	25	140	-0-	23	-0-	-0-	-0-	1	-0-	69	-0-	1	-0-
ISSISSIPPI (IV):																		
Cleveland	2,284	225	1,581	1	694	224	1,033	220	-0-	5	37	-0-	-0-	-0-	1,211	-0-	-0-	-0-
TENNESSEE (IV):																		
Kingston	128	5	27	-0-	101	5	31	5	-0-	-0-	2	-0-	-0-	-0-	95	-0-	-0-	-0-
ILLINOIS (V):																		
Cooks County	582	2	168	-0-	412	2	349	-0-	-0-	2	4	-0-	-0-	-0-	223	-0-	-0-	-0-
East St. Louis	104	2	12	-0-	92	2	85	1	-0-	-0-	11	-0-	-0-	-0-	7	1	-0-	-0-
Danville	286	-0-	84	-0-	202	-0-	178	-0-	-0-	-0-	3	-0-	-0-	-0-	105	-0-	-0-	-0-
OHIO (V):																		
Cincinnati																		
Dayton	288	15	1	4	287	11	174	3	5	-0-	-0-	-0-	-0-	-0-	112	5	1	-0-

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	C															
	CHILDREN RECEIVING DENTAL SERVICES DURING PROGRAM YEAR															
	CHILDREN RECEIVING DENTAL SERV. (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)	
								Non-HS				Non-HS				
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.
TEXAS (VI): Lubbock	195	-0-	4	-0-	191	-0-	37	-0-	-0-	-0-	-0-	-0-	-0-	-0-	158	-0-
Amarillo	609	7	67	1	542	6	43	-0-	1	-0-	45	-0-	-0-	-0-	520	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	117	-0-	8	-0-	109	-0-	117	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	159	3	11	-0-	147	3	70	-0-	3	-0-	1	-0-	-0-	-0-	88	-0-
MONTANA (VIII): Billings	136	8	4	-0-	132	8	83	-0-	2	-0-	-0-	-0-	-0-	-0-	53	-0-
Fort Peck (IMPD)	144	-0-	86	-0-	57	-0-	79	-0-	-0-	-0-	1	-0-	-0-	-0-	64	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	98	10	20	1	78	9	26	10	-0-	-0-	14	-0-	-0-	-0-	58	-0-
Fresno (IMPD)	4	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	3	-0-
OREGON (X): Medford	113	10	30	8	83	2	75	2	-0-	-0-	1	-0-	-0-	-0-	37	-0-
Eugene	82	31	~~4~~ 0	3	82	28	64	29	-0-	-0-	3	-0-	-0-	-0-	15	-0-

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	D															
	CHILDREN RECEIVING UNITS OF DENTAL SERVICES BY TYPE OF UNITS OF SERVICE (ASSESSMENT)															
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)	
								Non-HS				Non-HS				No
								a	b	c		a	b	c		a
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.
TOTALS FOR SELECTED PROJECTS	6,117	364	2,249	26	3,853	338	3,012	279	34	-0-	129	-0-	2	-0-	2,960	10
MASSACHUSETTS (I): Leominster	7	3	-0-	2	7	1	4	1	-0-	-0-	-0-	-0-	1	-0-	3	-0-
Worcester	369	7	3	7	365	-0-	256	-0-	-0-	-0-	6	-0-	-0-	-0-	106	-0-
NEW JERSEY (II): Trenton	24	8	-0-	-0-	24	8	20	4	-0-	-0-	-0-	-0-	-0-	-0-	4	4
Toms River	160	-0-	11	-0-	149	-0-	114	-0-	-0-	-0-	3	-0-	-0-	-0-	43	-0-
Paterson	63	5	13	-0-	50	5	62	5	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-
MARYLAND (III): Baltimore	210	25	129	-0-	80	25	139	-0-	23	-0-	-0-	-0-	1	-0-	69	-0-
MISSISSIPPI (IV): Cleveland	2,281	225	1,579	1	693	224	1,031	220	-0-	-0-	37	-0-	-0-	-0-	1,210	-0-
TENNESSEE (IV): Kingston	126	4	26	-0-	100	4	31	4	-0-	-0-	2	-0-	-0-	-0-	93	-0-
ILLINOIS (V): Cooks County	582	2	168	-0-	412	2	349	-0-	-0-	-0-	4	-0-	-0-	-0-	223	-0-
East St. Louis	104	2	12	-0-	92	2	85	1	-0-	-0-	11	-0-	-0-	-0-	7	1
Danville	261	-0-	74	-0-	187	-0-	159	-0-	-0-	-0-	3	-0-	-0-	-0-	99	-0-
OHIO (V): Cincinnati																
Dayton	287	15	1	4	286	11	173	3	5	-0-	-0-	-0-	-0-	-0-	112	5

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	D CHILDREN RECEIVING UNITS OF DENTAL SERVICES BY TYPE OF UNITS OF SERVICE (ASSESSMENT)																
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)		
								Non-HS				Non-HS				Non	
								a	b	c		a	b	c		a	b
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-
TEXAS (VI):																	
Lubbock	195	-0-	4	-0-	191	-0-	37	-0-	-0-	-0-	-0-	-0-	-0-	-0-	158	-0-	-0
Amarillo	608	7	67	1	541	6	43	-0-	1	-0-	45	-0-	-0-	-0-	519	-0-	
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MISSOURI (VII):																	
Springfield	117	-0-	8	-0-	109	-0-	117	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Appleton	159	3	11	-0-	147	3	70	-0-	3	-0-	1	-0-	-0-	-0-	88	-0-	-0
MONTANA (VIII):																	
Billings	134	8	4	-0-	130	8	81	-0-	2	-0-	-0-	-0-	-0-	-0-	53	-0-	
Fort Peck (IMPD)	144	-0-	86	-0-	57	-0-	79	-0-	-0-	-0-	1	-0-	-0-	-0-	64	-0-	-0
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
CALIFORNIA (IX):																	
El Centro	89	10	19	1	70	9	24	10	-0-	-0-	11	-0-	-0-	-0-	54		
Fresno (IMPD)	4	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	3	-0-	-0-
OREGON (X):																	
Medford	111	9	30	7	81	2	74	2	-0-	-0-	1	-0-	-0-	-0-	36	-0-	-0-
Eugene	82	31	-0-	3	82	28	64	29	-0-	-0-	3	-0-	-0-	-0-	15	-0-	2

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1 (Cont'd)

SELECTED PROJECTS BY STATE	D CHILDREN RECEIVING UNITS OF DENTAL SERVICES BY TYPE OF SERVICE (TREATMENT) TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)	
								Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c		Non-HS a
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.
TOTALS FOR SELECTED PROJECTS	7,949	643	3,317	36	4,615	607	3,803	589	14	-0-	169	-0-	4	-0-	3,973	6
MASSACHUSETTS (I):																
Leominster	24	8	-0-	4	24	4	8	4	-0-	-0-	4	-0-	-0-	-0-	12	-0-
Worcester	513	8	3	8	506	-0-	363	-0-	-0-	-0-	16	-0-	-0-	-0-	134	-0-
NEW JERSEY (II):																
Trenton	18	6	-0-	-0-	18	6	12	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	6
Toms River	274	-0-	24	-0-	250	-0-	213	-0-	-0-	-0-	6	-0-	-0-	-0-	55	-0-
Paterson	16	-0-	4	-0-	12	-0-	16	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III):																
Baltimore	107	-0-	59	-0-	48	-0-	75	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-
MISSISSIPPI (IV):																
Cleveland	3,692	455	2,849	-0-	830	455	1,627	451	-0-	-0-	34	-0-	-0-	-0-	2,031	-0-
TENNESSEE (IV):																
Kingston	263	14	53	-0-	210	14	42	14	-0-	-0-	6	-0-	-0-	-0-	215	-0-
ILLINOIS (V):																
Cooks County	147	-0-	54	-0-	93	-0-	94	-0-	-0-	-0-	4	-0-	-0-	-0-	49	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	428	-0-	135	-0-	293	-0-	237	-0-	-0-	-0-	12	-0-	-0-	-0-	179	-0-
OHIO (V):																
Cincinnati																
Dayton	32	-0-	-0-	-0-	32	-0-	24	-0-	-0-	-0-	-0-	-0-	-0-	-0-	8	-0-

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	D																
	CHILDREN RECEIVING UNITS OF DENTAL SERVICES BY TYPE OF SERVICE (TREATMENT)																
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)		
								Non-HS				Non-HS				Non	
								a	b	c		a	b	c		a	b
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-
TEXAS (VI): Lubbock	431	-0-	8	-0-	423	-0-	48	-0-	-0-	-0-	-0-	-0-	-0-	-0-	383	-0-	-
Amarillo	587	4	12	-0-	575	4	20	-0-	4	-0-	59	-0-	-0-	-0-	508	-0-	-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
MISSOURI (VII): Springfield	323	-0-	23	-0-	300	-0-	323	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Appleton	207	8	14	-0-	193	8	111	-0-	8	-0-	4	-0-	-0-	-0-	92	-0-	-0
MONTANA (VIII): Billings	175	8	6	-0-	169	8	108	-0-	2	-0-	-0-	-0-	-0-	-0-	67	-0-	
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
CALIFORNIA (IX): El Centro	81	12	9	-0-	72	12	27	12	-0-	-0-	12	-0-	-0-	-0-	42	-0-	-0
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
OREGON (X): Medford	307	16	64	12	243	4	199	4	-0-	-0-	-0-	-0-	4	-0-	108	-0-	-0
Eugene	324	104	-0-	12	324	92	256	104	-0-	-0-	12	-0-	-0-	-0-	56	-0-	-0

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1 (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CASES COMPLETED																	
			PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	5591	357	2156	28	3422	328	2678	272	33	-0-	130	-0-	6	-0-	2771	3	15	27
MASSACHUSETTS (I): Leominster	10	12	-0-	5	10	7	8	3	3	-0-	1	-0-	4	-0-	1	-0-	1	-0-
Worcester	368	10	3	10	364	-0-	253	-0-	-0-	-0-	6	-0-	-0-	-0-	108	-0-	-0-	10
NEW JERSEY (II): Trenton	23	7	-0-	-0-	23	7	19	3	-0-	-0-	-0-	-0-	-0-	-0-	4	1	-0-	3
Toms River	166	-0-	13	-0-	153	-0-	118	-0-	-0-	-0-	3	-0-	-0-	-0-	45	-0-	-0-	-0-
Paterson	57	3	11	-0-	46	3	57	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	172	25	110	-0-	61	25	115	-0-	23	-0-	-0-	-0-	1	-0-	57	-0-	1	-0-
MISSISSIPPI (IV): Cleveland	2293	228	1577	1	707	226	1037	221	1	-0-	39	-0-	-0-	-0-	1214	-0-	-0-	6
TENNESSEE (IV): Kingston	128	4	27	-0-	101	4	28	4	-0-	-0-	2	-0-	-0-	-0-	98	-0-	-0-	-0-
ILLINOIS (V): Cooks County	553	2	161	-0-	390	2	337	-0-	-0-	-0-	2	-0-	-0-	-0-	209	-0-	-0-	2
East St. Louis	37	-0-	9	-0-	28	-0-	22	-0-	-0-	-0-	10	-0-	-0-	-0-	4	-0-	-0-	-0-
Danville	234	-0-	68	-0-	166	-0-	140	-0-	-0-	-0-	3	-0-	-0-	-0-	91	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	112	6	1	1	111	5	61	3	1	-0-	-0-	-0-	-0-	-0-	50	1	1	-0-

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-C1 (Cont'd)

SELECTED PROJECTS BY STATE	E																				
	CASES COMPLETED																				
			PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER						
								Non-HS				Non-HS				Non-HS					
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.			
TEXAS (VI):																					
Lubbock	186	1	3	-0-	183	1	33	-0-	-0-	-0-	-0-	-0-	-0-	-0-	153	1	-0-	-0-			
Amarillo	586	7	61	1	525	6	42	-0-	-0-	-0-	44	-0-	-0-	-0-	499	-0-	6	-0-			
Laredo (IMPD)	-0-		-0-		-0-		-0-				-0-				-0-						
MISSOURI (VII):																					
Springfield	117	-0-	8	-0-	109	-0-	117	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-			
Appleton	128	2	11	-0-	117	2	62	-0-	2	-0-	1	-0-	-0-	-0-	65	-0-	-0-	-0-			
MONTANA (VIII):																					
Billings	112	8	4	-0-	108	8	69	-0-	2	-0-	-0-	-0-	-0-	-0-	43	-0-	6	-0-			
Fort Peck (IMPD)	22	-0-	12	-0-	10	-0-	18	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-			
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-			
CALIFORNIA (IX):																					
El Centro	96	10	21	1	75	9	25	10	-0-	-0-	14	-0-	-0-	-0-	57	-0-	-0-	-0-			
Fresno (IMPD)	26	-0-	26	-0-	-0-	-0-	2	-0-	-0-	-0-	2	-0-	-0-	-0-	22	-0-	-0-	-0-			
OREGON (X):																					
Medford	114	10	30	7	84	3	76	3	-0-	-0-	1	-0-	-0-	-0-	37	-0-	-0-	6			
Eugene	51	22	-0-	2	51	20	39	22	-0-	-0-	2	-0-	-0-	-0-	10	-0-	-0-	-0-			

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	F											
	CASES REQUIRING FOLLOW-UP											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TOTALS FOR SELECTED PROJECTS	613	25	129	4	481	20	369	17	8	-0-	232	7
MASSACHUSETTS (I): Leominster	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Worcester	1	-0-	-0-	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-
NEW JERSEY (II): Trenton	1	1	-0-	-0-	1	1	1	1	-0-	-0-	-0-	-0-
Toms River	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	6	2	2	-0-	3	2	3	2	-0-	-0-	2	-0-
MARYLAND (III): Baltimore	39	-0-	20	-0-	19	-0-	25	-0-	-0-	-0-	12	-0-
MISSISSIPPI (IV): Cleveland	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
TENNESSEE (IV): Kingston	-0-	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-
ILLINOIS (V): Cook County	29	-0-	7	-0-	22	-0-	12	-0-	2	-0-	14	-0-
East St. Louis	67	2	3	-0-	64	2	63	1	1	-0-	3	1
Danville	52	-0-	16	-0-	36	-0-	38	-0-	0	-0-	14	-0-
OHIO (V): Cincinnati												
Dayton	176	9	-0-	3	176	6	113	4	-0-	-0-	62	4

DENTAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-Cl (Cont'd)

SELECTED PROJECTS BY STATE	F											
	CASES REQUIRING FOLLOW-UP											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TEXAS (VI): Lubbock	9	-0-	1	-0-	8	-0-	4	-0-	-0-	-0-	5	-0-
Amarillo	23	-0-	6	-0-	17	-0-	1	-0-	2	-0-	21	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	31	1	-0-	-0-	30	-0-	8	1	-0-	-0-	23	-0-
MONTANA (VIII): Billings	24	-0-	-0-	-0-	24	-0-	14	-0-	-0-	-0-	10	-0-
Fort Peck (IMPD)	122	-0-	74	-0-	47	-0-	61	-0-	1	-0-	60	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	1	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	31	9	-0-	1	31	8	25	7	1	-0-	5	2

D. RECEIPT OF MENTAL HEALTH SERVICES

1. Analysis of Findings

Children Receiving Mental Health Services (C)

Aggregate Totals

Nationally, 9,623 children received mental health services, compared to 2,450 previously reported, representing a fourfold increase. Of this group, 92%, or 8,826 were enrolled in Head Start. For the selected projects, 3,014 children were reported to have received mental health services, compared to 290 previously, a fourfold increase.

A majority of the regions, eight out of eleven, reported at least twice the number of these services provided prior to the mental health services as compared to those provided prior to the collaborative effort. Two regions--I and IV - had increases higher than the national average, at 1100% and 400% respectively. Regions III and X did less well. In fact, Region III reported a decrease in the number of children receiving mental health services this year, while Region X registered an increase of only 1%.

The greatest proportion of Head Start children relative to non-Head Start children receiving mental health services this year was in Region V (340 to 3). Region VII had no non-Head Start children receiving mental health services. Region X had a lower differential between Head Start and non-Head Start in this category (64 to 12). Most of the regions approximated the national average, however.

Region IV did have a marked increase of non-Head Start children served compared to those reported prior to the demonstration program (32 to 575). Regions V, VII, and the IMPD projects reported fewer non-Head Start children receiving mental health services than those previously reported.

Selected Projects

The total number of Head Start children receiving mental health services increased tenfold compared to those in receipt of such services prior to the demonstration program. The number of projects reporting in this category also increased this year from 15 to 21.* Cleveland accounted for 70% of the Head Start children reported this year (2,197 out of 2,946). The next highest was Billings, with 144. Fifteen projects had five or fewer Head Start children in this category and five of these projects--Paterson, East St. Louis, Danville, Fort Peck and Fresno--each had no more than two.

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*Eugene did not report any children in this category.

The majority of the Head Start children, 51%, were previous enrollees, in contrast to the incidence of previous enrollment of Head Start children reported for medical and dental services. (Cleveland accounted for 1,424 children in this group.)

Nineteen of the twenty-one projects reporting, however, listed a greater number of Head Start children as not previously enrolled. In fact, ten reported that none of their children had been in Head Start prior to the collaborative effort.

The majority (50%) of the Head Start children receiving mental health services were Medicaid certified. Of this group, Cleveland had the highest number (1007 out of 1,446). Slightly more than half of this particular project's Head Start children were Medicaid Other, however. Thirteen projects had a majority of their Head Start children receiving mental health services as Medicaid certified, and three of them--Paterson, East St. Louis, and Springfield--reported all their Head Start children in this category.

Six projects--Leominster, Worcester, Cleveland, Billings and Medford--reported a total of 71 non-Head Start children receiving mental health services this year. This is a 12% increase from the number reported for the period prior to the collaborative effort. However, the number of projects reporting in this category doubled from three to six.

Billings had the highest number of non-Head Start children reported (27) and Leominster was next with 19. Over three-quarters of the non-Head Start children receiving mental health services were not previous enrollees. Billings had no children previously enrolled.

Precisely one half of the non-Head Start children receiving mental health services were Medicaid certified. Of this group, the majority, 21 out of 35, were siblings of Head Start enrollees. Non-siblings constituted the majority of those non-Head Start children recorded as Medicaid Other.

Children Psychologically Tested/Evaluated (D)

Aggregate Totals

Of the 9,623 children receiving mental health services this year nationally, 92% or 8,800 were psychologically tested. The nature or extent of this testing is unknown. It is reasonable to expect, however, given such a high incidence, that the tests were primarily an assessment procedure.

The vast majority, (91% or 8,059 out of 8,800) of the children receiving these evaluations were Head Start enrollees. For the selected projects, 97%, or 2,944 out of 3,014, of the children served were tested and 92% of them were part of the Head Start program.

All the regions except Region I reported substantial portions (at least 77%) of the children receiving mental health services as being tested. Except for Regions V and VII, all others indicated that the children tested were predominantly in the Head Start program.

Selected Projects

Twenty projects (Leominster not reporting in this category) had a total of 2,903 Head Start children receiving psychological evaluation, or 98% of the total group served. Cleveland was the highest, with 2,197, and Billings was next, with 148. Four projects--Paterson, East St. Louis, Fort Peck and Fresno--had no more than two each.

Even though the majority (51%) of the Head Start children being tested were previously enrolled (Cleveland accounted for most of this group), most of the projects, (17 out of 20), indicated a greater number of their Head Start children as not previously enrolled.

Over half of the Head Start children tested were Medicaid certified, with most of the remainder (49%) cited as Medicaid Other. Twelve projects reported a majority of the Head Start children in this category and in three--Baltimore, East St. Louis, and Springfield--all were.

Only 41 non-Head Start children received psychological evaluations and these were all in three projects--Trenton, Cleveland and Billings. None of these children had been in Head Start previously. Of these non-Head Start children, 68% were Medicaid certified and most were siblings of Head Start enrollees. Non-siblings, however, constituted the majority of both Medicaid certified and Other children.

Children Referred (E)

Aggregate Totals

Only 13% of the children receiving mental health services nationally (1,260 out of 9,623) were referred for further services. There is no information regarding the extent that referrals occurred as a result of psychological testing. For the seelcted projects, the referral rate was much lower at 5%. Again, there is minimal variation from the national pattern at the regional level, although Region X did have a much higher rate of referrals, 52%.

Head Start children represented 90% of the group referred (1,177 out of 1,260). Five regions--Regions V, VII, IX, X, and the IMPD projects--reported four to no Non-Head Start children referred.

Selected Projects

Nineteen projects reported a total of 179 Head Start children, or about 6% of the children receiving mental health services this year. Appleton had the highest number of Head Start children referred (45) and the next highest was Kingston with 31. Two projects--East St. Louis and Fort Peck--did not report any children in this category. Cleveland, with the highest number of children receiving mental health services, reported eight referrals, a rate of less than 1%.

Most 80%) of the Head Start children referred, were not previously enrolled in the program. Of the 19 projects reporting, even had no previously enrolled Head Start children. Around 53% of the 179 referrals represented Medicaid certified Head Start children. In 11 of the 19 projects, all or a majority of the Head Start children were Medicaid certified. In five projects, however--Cleveland, Kingston, Amarillo, Fresno and Medford--the majority of the referred children were Medicaid Other.

Only six non-Head Start children were referred for mental health services and these were from Trenton, Cleveland, and Billings. None of the children were previous enrollees, and two out of three were non-siblings who were either Medicaid certified or Other.

Children Counseled (F)

The rate for counseling services received was also relatively low, with 16% or 1,595 out of 9,623 children nationally receiving such services. Again, it is not known whether these services were a consequence of psychological testing. For the selected projects, the rate for provision of counseling service was even lower at 4%.

Regions III and X reported considerably higher rates of children counseled relative to the receipt of mental health services--92% and 51% respectively. The rates for the other regions ranged from ten percent to 33%.

Head Start children represented the greater proportion, 89%, of those counseled nationally. For the selected projects, the percentage of Head Start children to the total group counseled was over 90% (157 out of 163). Six regions reported very few (5) to no non-Head Start children counseled.

Selected Projects

Only 4% of the Head Start children receiving mental health services this year were reported as counseled by eighteen projects. Kingston had the highest number with 19. Four others--Appleton, Billings, Cleveland and Danville--reported almost the same number (18,17,17, and 16 respectively). On the other hand, two projects--Paterson, and Fresno--cited only one Head Start child each.

Almost three-quarters, (74%), of the Head Start children counseled were not previous enrollees. Six projects had no Head Start children reported as previously enrolled. Four others, however, stated that a majority of their Head Start children who were counseled were previously enrolled.

Of the 157 Head Start children counselled, 56% were Medicaid certified. In 11 projects the majority of the Head Start children were certified and in two--Paterson, Baltimore and they all were.

Only six non-Head Start children were counselled and they had the same characteristics as those cited for the group that was referred for further services.

Cases Completed (G)

Aggregate Totals

Most of the children receiving mental health services nationally had completed cases--84% or 8,154 out of 9,623. For the selected projects, the incidence was somewhat higher at 95%. Again, Head Start children were the predominant part of this group. There was wide regional variation in this category with Region III reporting only 9% completed and Region VIII and X reporting 52% and 48% respectively.

Selected Projects

Of the 2,946 Head Start children receiving mental health services in the selected projects, 91%, or 2,842, had completed cases reported by 20 projects. Cleveland had the highest with 2,175;

Springfield, Billings and Appleton followed with 116, 115, and 112 respectively.

The majority (52%) of the Head Start children, whose cases were completed had been previously enrolled in Head Start (Cleveland again accounted for most of this group). Seventeen projects, however, had a majority of their children listed as not previously enrolled and nine of them reported no Head Start children as previously enrolled.

Over half of the Head Start children who had completed mental health services were Medicaid certified (1,360 out of 2,771) and Medicaid Other accounted for almost as many of this group. Fourteen projects, however, reported a majority of their Head Start children with completed services as Medicaid certified.

Seven projects reported a total of 71 completed mental health cases for non-Head Start children (Kingston reported three in this category even though it had not indicated any non-Head Start children receiving mental health services.)

Almost three-quarters (74%) of these non-Head Start children were not previous enrolled. Worcester, however, reported that all of its non-Head Start had been in the program prior to the collaborative effort. Half of the non Head Start children were Medicaid certified, and these, 50% siblings of Head Start enrollees. Non-siblings made up the majority of Medicaid Other.

Children Requiring Follow-Up (H)

Aggregate Totals

As expected from the rate reported for completed cases, only 15% of the children served for mental health purposes needed further services and the major portion of these were Head Start enrollees (94%). For the selected projects, only 3% of the children required follow-up and Head Start children were in the majority here also. Three regions deviated markedly from this pattern--Regions III, V, and X--where 90%, 64% and 51% of the children receiving mental health services during the year required follow-up.

Selected Projects

Only 5% (175 out of 2,946) of the Head Start children receiving mental health services in the selected projects required follow-up services as reported by 17 projects. Kingston and Billings were highest each with 29. Four projects--Leominster, Paterson, Fresno and Eugene--reported no Head Start children in need of follow-up.

Again, almost three-quarters (74%) of these Head Start children had not been enrolled in the program previously. Of the 17 projects reporting, 12 stated that a majority of their children were not previously enrolled.

About half of the Head Start children requiring follow-up services were Medicaid certified. The majority of the projects reporting--nine--had a greater number of their children as Medicaid certified. Five projects had the majority as Medicaid Other and one of these--Amarillo--had all Other.

Billings was the only project reporting non-Head Start children needing follow-up, listing three in this category, none of whom were previously enrolled and two of whom were Medicaid certified.

2. Conclusions on Receipt of Mental Health Services

- There was a sharp increase, four to one, in the number of children receiving mental health services nationally, compared to those in receipt of such services just prior to the collaborative effort. This increase was maintained at the regional level (except for Region III) and the selected projects did even better, with a tenfold increase reported.
- A vast majority (over 90%) of the children, Head Start and non-Head Start, received psychological testing, but the purpose, as well as the nature, of the tests administrated is not known. Relatively few of these children were

referred or counseled as part of the mental health services provided. This low incidence for referral and counseling is more likely to reflect the lack of resources within the Head Start program and the community, rather than any evidence of a highly psychologically healthy population.

- Most of the children receiving mental health services required very little follow-up, again suggesting that the services provided were primarily short-term testing rather than on-going treatment.

MENTAL HEALTH SERVICES BY AGGREGATED TOTALS

Table XVI-D

	A			B			C			D		
	CHILDREN PARTICIPATING CUMULATIVE			CHILDREN WITH PREVIOUS MENTAL HEALTH SERVICE			CHILDREN RECEIVING MENTAL HEALTH SERVICES			CHILDREN PSYCHOLOGICALLY TESTED/EVALUATED		
	1	2	3	1	2	3	1	2	3	1	2	3
	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS	TOTAL	HS	NHS
NATIONAL TOTALS	52,189	38,912	13,277	2,450	2,248	202	9,623	8,826	797	8,800	8,057	743
SELECTED PROJECTS	9,561	5,691	3,870	290	232	58	3,014	2,946	68	2,944	2,903	41
OTHER PROJECTS	42,628	33,221	9,470	2,160	2,016	144	6,606	5,880	729	5,856	5,154	702
REGION: I	4,566	2,444	2,122	60	44	16	723	695	28	682	661	21
II	4,368	2,636	1,732	271	202	69	432	379	53	398	353	45
III	2,810	2,416	394	164	162	2	129	124	5	72	68	4
IV	9,420	7,373	2,047	790	758	32	4,705	4,130	575	4,223	3,677	546
V	7,196	5,194	2,002	174	157	17	343	340	3	258	257	1
VI	13,119	12,178	941	417	396	21	1,583	1,537	46	1,571	1,526	45
VII	1,893	k,652	241	209	207	2	540	540	-0-	499	499	-0-
VIII	4,674	3,284	1,390	299	263	36	822	772	50	774	725	49
IX	649	567	127	11	10	1	270	245	25	260	239	21
X	3,449	1,168	2,281	55	49	6	76	64	12	63	52	11
*IMPD	1,887	1,139	748	157	145	12	287	276	11	241	231	10

* Not included in totals. Amounts are dispersed throughout regional totals.

MENTAL HEALTH SERVICES BY AGGREGATED TOTALS

Table XVI-D (Continued)

	E			F			G			H		
	CHILDREN REFERRED			CHILDREN COUNSELED			CASES COMPLETED			CASES REQUIRING FOLLOW-UP		
	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS
NATIONAL TOTALS	1,260	1,177	83	1,595	1,500	95	8,154	7,456	698	1,469	1,370	99
SELECTED PROJECTS	185	179	6	163	157	6	2,842	2,771	71	178	175	3
OTHER PROJECTS	1,075	998	77	1,432	1,343	89	5,312	4,685	627	1,291	1,195	96
REGION: I	97	81	16	88	78	10	629	617	12	94	78	16
II	132	118	14	94	84	10	396	360	36	36	19	17
III	24	20	4	119	118	1	12	11	1	117	113	4
IV	319	312	7	607	569	38	4,327	3,762	565	378	368	10
V	156	155	1	147	144	3	116	113	3	227	227	-0-
VI	137	121	16	127	111	16	1,543	1,513	30	40	24	16
VII	134	134	-0-	142	142	-0-	436	436	-0-	104	104	-0-
VIII	183	165	18	213	197	16	430	390	40	392	382	10
IX	38	34	4	19	19	-0-	228	228	-0-	42	17	25
X	40	37	3	39	38	1	37	26	11	39	38	1
*IMPD	80	76	4	73	68	5	262	256	6	25	20	5

* Not included in totals. Amounts are dispersed throughout regional totals.

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1

SELECTED PROJECTS BY STATE	A	
	CHILDREN PARTICIPATING CUMULATIVE	
	HS	NHS
TOTALS FOR SELECTED PROJECTS	5,691	3,870
MASSACHUSETTS (I): Leominster	264	71
Worcester	464	279
NEW JERSEY (II): Trenton	282	102
Toms River	129	40
Paterson	190	210
MARYLAND (III): Baltimore	488	137
MISSISSIPPI (IV): Cleveland		
TENNESSEE (IV): Kingston	167	94
ILLINOIS (V): Cooks County	499	407
East St. Louis	458	155
Danville	282	
OHIO (V): Cincinnati		
Dayton		
TEXAS (VI): Lubbock	112	3
Amarillo	896	45
Laredo (IMPD)		
MISSOURI (VII): Springfield	515	106
Appleton		
MONTANA (VIII): Billings	147	20
Fort Peck (IMPD)		
Blackfeet (IMPD)		
CALIFORNIA (IX): El Centro		
Fresno (IMPD)		
OREGON (X): Medford	152	1,650
Eugene	128	101

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TOTALS FOR SELECTED PROJECTS	N/A	N/A	N/A	N/A	N/A	N/A	191	56	-0-	2	41	-0-
MASSACHUSETTS (I): Leominster	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Worcester	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	3	-0-
NEW JERSEY (II): Trenton	N/A	N/A	N/A	N/A	N/A	N/A	6	-0-	-0-	-0-	1	-0-
Toms River	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	1	-0-
Paterson	N/A	N/A	N/A	N/A	N/A	N/A	8	53	-0-	2	-0-	-0-
MARYLAND (III): Baltimore	N/A	N/A	N/A	N/A	N/A	N/A	7	-0-	-0-	-0-	1	-0-
MISSISSIPPI (IV): Cleveland												
TENNESSEE (IV): Kingston	N/A	N/A	N/A	N/A	N/A	N/A	-0-	2	-0-	-0-	2	-0-
ILLINOIS (V): Cook County	N/A	N/A	N/A	N/A	N/A	N/A	35	-0-	-0-	-0-	19	-0-
East St. Louis	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Danville	N/A	N/A	N/A	N/A	N/A	N/A	6	-0-	-0-	-0-	2	-0-
OHIO (V): Cincinnati												
Dayton												

N/A = Information Not Available

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TEXAS (VI): Lubbock	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	1	-0-
Amarillo	N/A	N/A	N/A	N/A	N/A	N/A	1	-0-	-0-	-0-	5	-0-
Laredo (IMPD)												
MISSOURI (VII): Springfield	N/A	N/A	N/A	N/A	N/A	N/A	119	-0-	-0-	-0-	-0-	-0-
Appleton												
MONTANA (VIII): Billings	N/A	N/A	N/A	N/A	N/A	N/A	4	-0-	-0-	-0-	2	-0-
Fort Peck (IMPD)	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	1	-0-
Blackfeet (IMPD)	N/A	N/A	N/A	N/A	N/A	N/A	1	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro												
Fresno (IMPD)	N/A	N/A	N/A	N/A	N/A	N/A	4	-0-	-0-	-0-	3	-0-
OREGON (X): Medford	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-

N/A = Information Not Available

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN RECEIVING MENTAL HEALTH SERVICES DURING PROGRAM YEAR																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	2,946	68	1,511	17	1,427	54	1,446	14	21	-0-	62	1	4	-0-	1,435	7	14	9
MASSACHUSETTS (I): Leominster	3	19	-0-	7	3	12	2	4	6		-0-	1	4		1	3	-0-	-0-
Worcester	9	3	-0-	3	9	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	3	
NEW JERSEY (II): Trenton	23	8	-0-	-0-	23	8	19	4	-0-	-0-	-0-	-0-	-0-	-0-	4	4	-0-	-0-
Toms River	28	-0-	1	-0-	27	-0-	19	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-
Paterson	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	5	-0-	3	-0-	2	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	2,197	6	1,424	-0-	765	6	1,007	5	-0-	-0-	43	-0-	-0-	-0-	1,144	-0-	-0-	1
TENNESSEE (IV): Kingston	31	-0-	6	-0-	25	-0-	7	-0-	-0-	-0-	1	-0-	-0-	-0-	23	-0-	-0-	-0-
ILLINOIS (V): Cooks County	68	-0-	14	-0-	54	-0-	43	-0-	-0-	-0-	2	-0-	-0-	-0-	23	-0-	-0-	-0-
East St. Louis	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	23	-0-	6	-0-	18	-0-	17	-0-	-0-	-0-	1	-0-	-0-	-0-	5	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	3	-0-	-0-	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN RECEIVING MENTAL HEALTH SERVICES DURING PROGRAM YEAR																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI):																		
Lubbock	33	-0-	1	-0-	32	-0-	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-	-0-
Amarillo	9	-0-	3	-0-	6	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	7	-0-	-0-	-0-
Laredo (IMPD)																		
MISSOURI (VII):																		
Springfield	117	-0-	8	-0-	109	-0-	117	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	130	-0-	11	-0-	119	-0-	61	-0-	-0-	-0-	-0-	-0-	-0-	-0-	69	-0-	-0-	-0-
MONTANA (VIII):																		
Billings	144	24	5	-0-	139	27	91	1	14	-0-	-0-	-0-	-0-	-0-	53	-0-	11	1
Fort Peck (IMPD)	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX):																		
El Centro	95	-0-	21	-0-	74	-0-	25	-0-	-0-	-0-	14	-0-	-0-	-0-	56	-0-	-0-	-0-
Fresno (IMPD)	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OREGON (X):																		
Medford	23	8	8	7	15	1	17	-0-	1	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	7
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN PSYCHOLOGICALLY TESTED AND EVALUATED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	2,903	41	1,500	-0-	1,400	40	1,428	10	14	-0-	61	-0-	-0-	-0-	1,411	4	11	2
ASSACHUSETTS (I): Leominster	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Worcester	9	-0-	-0-	-0-	9	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
EW JERSEY (II): Trenton	23	8	-0-	-0-	23	8	19	4	-0-	-0-	-0-	-0-	-0-	-0-	4	4	-0-	-0-
Toms River	28	-0-	1	-0-	27	-0-	19	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-
Paterson	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
ARYLAND (III): Baltimore	5	-0-	3	-0-	2	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
ISSISSIPPI (IV): Cleveland	2,197	6	1,424	-0-	765	5	1,007	5	-0-	-0-	43	-0-	-0-	-0-	1,144	-0-	-0-	1
TENNESSEE (IV): Kingston	5	-0-	-0-	-0-	5	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
LLINOIS (V): Cooks County	66	-0-	14	-0-	52	-0-	41	-0-	-0-	-0-	2	-0-	-0-	-0-	23	-0-	-0-	-0-
East St. Louis	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	20	-0-	2	-0-	18	-0-	14	-0-	-0-	-0-	1	-0-	-0-	-0-	5	-0-	-0-	-0-
HIO (V): Cincinnati																		
Dayton	3	-0-	-0-	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN PSYCHOLOGICALLY TESTED AND EVALUATED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	33	-0-	1	-0-	32	-0-	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-	-0-
Amarillo	8	-0-	3	-0-	5	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	6	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	117	-0-	8	-0-	109	-0-	117	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	129	-0-	11	-0-	118	-0-	60	-0-	-0-	-0-	-0-	-0-	-0-	-0-	69	-0-	-0-	-0-
MONTANA (VIII): Billings	143	27	5	-0-	138	27	91	1	14	-0-	-0-	-0-	-0-	-0-	52	-0-	11	1
Fort Peck (IMPD)	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	95	-0-	21	-0-	74	-0-	25	-0-	-0-	-0-	14	-0-	-0-	-0-	56	-0-	-0-	-0-
Fresno (IMPD)	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OREGON (X): Medford	17	-0-	6	-0-	11	-0-	13	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CHILDREN REFERRED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	179	6	37	-0-	142	6	95	1	2	-0-	4	-0-	-0-	-0-	80	2	-0-	1
MASSACHUSETTS (I): Leominster	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Worcester	5	-0-	-0-	-0-	5	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
NEW JERSEY (II): Trenton	5	2	-0-	-0-	5	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	2	-0-	-0-
Toms River	6	-0-	1	-0-	5	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Paterson	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	8	1	6	-0-	2	1	3	1	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
TENNESSEE (IV): Kingston	31	-0-	6	-0-	25	-0-	7	-0-	-0-	-0-	1	-0-	-0-	-0-	23	-0-	-0-	-0-
ILLINOIS (V): Cooks County	15	-0-	4	-0-	11	-0-	10	-0-	-0-	-0-	2	-0-	-0-	-0-	3	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	9	-0-	5	-0-	4	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OHIO (V): Cincinnati	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Dayton	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CHILDREN REFERRED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Amarillo	7	-0-	2	-0-	5	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	8	-0-	1	-0-	7	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	45	-0-	3	-0-	42	-0-	23	-0-	-0-	-0-	-0-	-0-	-0-	-0-	22	-0-	-0-	-0-
MONTANA (VIII): Billings	14	3	-0-	-0-	14	3	7		2	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	1
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	2	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fresno (IMPD)	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-
OREGON (X): Medford	15	-0-	6	-0-	9	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	11	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	F																	
	CHILDREN COUNSELED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	157	6	39	-0-	118	6	91	1	2	-0-	-0-	-0-	-0-	-0-	66	2	-0-	1
MASSACHUSETTS (I): Leominster	3	-0-	-0-	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Worcester	6	-0-	-0-	-0-	6	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
NEW JERSEY (II): Trenton	5	2	-0-	-0-	5	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	2	-0-	-0-
Toms River	12	-0-	1	-0-	11	-0-	10	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Paterson	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	17	1	12	-0-	5	1	7	1	-0-	-0-	-0-	-0-	-0-	-0-	10	-0-	-0-	-0-
TENNESSEE (IV): Kingston	19	-0-	4	-0-	15	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	15	-0-	-0-	-0-
ILLINOIS (V): Cooks County	9	-0-	2	-0-	7	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	16	-0-	4	-0-	12	-0-	12	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
OHIO (V): Cincinnati	-0-	-0-																
Dayton	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	F																	
	CHILDREN COUNSELED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	3	-0-	-0-	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Amarillo	5	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	6	-0-	1	-0-	5	-0-	6	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	18	-0-	3	-0-	15	-0-	9	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-
MONTANA (VIII): Billings	17	3	1	-0-	16	3	10	-0-	2	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	1
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fresno (IMPD)	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OREGON (X): Medford	15	-0-	6	-0-	9	-0-	10	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	G																	
	CASES COMPLETED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	2,771	68	1,468	17	1,295	50	1,360	15	18	-0-	59	1	4	-0-	1,350	4	14	11
ASSACHUSETTS (I): Leominster	3	19	-0-	7	3	12	2	4	6	-0-	-0-	1	4	-0-	1	-0-	3	-0-
Worcester	4	3	-0-	3	4	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	3
EW JERSEY (II): Trenton	17	8	-0-	-0-	17	8	15	4	-0-	-0-	-0-	-0-	-0-	-0-	2	4	-0-	-0-
Toms River	26	-0-	1	-0-	25	-0-	18	-0-	-0-	-0-	-0-	-0-	-0-	-0-	8	-0-	-0-	-0-
Paterson	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	3	-0-	2	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
ISSISSIPPI (IV): Cleveland	2,175	6	1,410	-0-	757	5	999	5	-0-	-0-	43	-0-	-0-	-0-	1,130	-0-	-0-	1
TENNESSEE (IV): Kingston	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
ILLINOIS (V): Cooks County	58	-0-	12	-0-	46	-0-	35	-0-	-0-	-0-	2	-0-	-0-	-0-	21	-0-	-0-	-0-
East St. Louis	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	G																	
	CASES COMPLETED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI):																		
Lubbock	30	-0-	1	-0-	29	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	28	-0-	-0-	-0-
Amarillo	4	-0-	-0-	-0-	4	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	2	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII):																		
Springfield	116	-0-	7	-0-	109	-0-	116	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	112	-0-	9	-0-	103	-0-	50	-0-	-0-	-0-	-0-	-0-	-0-	-0-	62	-0-	-0-	-0-
MONTANA (VIII):																		
Billings	115	24	3	-0-	112	24	78	1	12	-0-	-0-	-0-	-0-	-0-	37	-0-	11	-0-
Fort Peck (IMPD)	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX):																		
El Centro	90	-0-	19	-0-	71	-0-	23	-0-	-0-	-0-	13	-0-	-0-	-0-	54	-0-	-0-	-0-
Fresno (IMPD)	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
OREGON (X):																		
Medford	9	8	3	7	6	1	9	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	7
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	H CASES REQUIRING FOLLOW-UP TOTAL HS	TOTAL NHS	PREVIOUSLY ENROLLED HS	PREVIOUSLY ENROLLED NHS	NOT PREVIOUSLY ENROLLED HS	NOT PREVIOUSLY ENROLLED NHS	MEDICAID CERTIFIED HS	MEDICAID CERTIFIED Non-HS Sib.	MEDICAID CERTIFIED Non-HS Non-Sib.	MEDICAID CERTIFIED Non-HS Oth.	NOT MEDICAID CERTIFIED HS	NOT MEDICAID CERTIFIED Non-HS Sib.	NOT MEDICAID CERTIFIED Non-HS Non-Sib.	NOT MEDICAID CERTIFIED Non-HS Oth.	OTHER HS	OTHER Non-HS Sib.	OTHER Non-HS Non-Sib.	OTHER Non-HS Oth.
OTALS FOR ELECTED PROJECTS	175	3	43	-0-	132	3	86	-0-	2	-0-	4	-0-	-0-	-0-	85	-0-	-0-	1
ASSACHUSETTS (I):																		
Leominster	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Worcester	5	-0-	-0-	-0-	5	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
EW JERSEY (II):																		
Trenton	6	-0-	-0-	-0-	6	-0-	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Toms River	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
ARYLAND (III):																		
Baltimore	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
ISSISSIPPI (IV):																		
Cleveland	22	-0-	14	-0-	8	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	14	-0-	-0-	-0-
TENNESSEE (IV):																		
Kingston	29	-0-	6	-0-	23	-0-	6	-0-	-0-	-0-	1	-0-	-0-	-0-	22	-0-	-0-	-0-
LLINOIS (V):																		
Cooks County	10	-0-	2	-0-	8	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	21	-0-	6	-0-	16	-0-	16	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
HIO (V):																		
Cincinnati																		
Dayton	2	-0-	-0-	-0-	2	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-

MENTAL HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-D1 (Cont'd)

SELECTED PROJECTS BY STATE	H																	
	CASES REQUIRING FOLLOW-UP																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	3	-0-	-0-	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Amarillo	5	-0-	3	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	1	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	18	-0-	2	-0-	16	-0-	11	-0-	-0-	-0-	-0-	-0-	-0-	-0-	7	-0-	-0-	-0-
MONTANA (VIII): Billings	29	3	2	-0-	27	3	13	-0-	2	-0-	-0-	-0-	-0-	-0-	16	-0-	-0-	1
Fort Peck (IMPD)	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	5	-0-	2	-0-	3	-0-	2	-0-	-0-	-0-	1	-0-	-0-	-0-	2	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	14	-0-	5	-0-	9	-0-	8	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

E. RECEIPT OF NUTRITIONAL SERVICE

1. Analysis of Findings

Children Receiving Nutritional Services (C)

Aggregate Totals

Relatively few children received nutritional services nationally, compared to Medicaid dental and mental health services, since only a total of 3,347 children were cited in this category. This total did represent, however, almost threefold increase from the number reported as receiving such services prior to the collaborative effort. For the selected projects the increase was less than two to one (155 to 99).

All regions reported an increase in the number of children receiving nutritional services this year, except Region III which registered a decrease from the previous year (75 to 14). The most substantial increases were in Region IX and Region X. Region VI had the smallest increase, 30%.

Head Start children constituted the overwhelming majority (84% or 2,827 out of 3,347) of children receiving nutritional services, and the rate of increase from the previous year was comparable to the national average. Region IV had a greater increase in non-Head Start rather than Head Start children, relative to the previous year's experience. Region VII, on the other hand, reported no non-Head Start children served.

Selected Projects

There was also a three to one increase in the total number of Head Start children receiving nutritional services this year compared to those served previously (150 to 43). Thirteen, projects provided data in this category, an increase of four from the previous year.

Over 90% of the Head Start children were not previously enrolled in the program. All the projects except Cleveland reported a majority of their Head Start children in this category as not previously enrolled, but nine projects reported no such children.

A majority (57%) of the Head Start children receiving nutritional service were Medicaid certified. Of the 13 projects reporting, seven had a majority of their Head Start children listed as Medicaid certified, with four of them--Worcester, Toms River, Appleton and Medford--having all their children categorized as certified. Cleveland, Kingston and Amarillo, meanwhile, had Medicaid Other children in the majority.

A total of three projects--Leominster, Trenton, and Cleveland reported only five non-Head Start children as receiving nutritional services this year. The number reported represents a 500% decrease from the previous year. All five of these children were not previously enrolled in Head Start, and most of them were siblings and either Medicaid certified or Other.

Children Referred For Further Assessment/Evaluation (D)

Aggregate Totals

In sharp contrast to the referral rate for mental health services, three-quarters of the children (2,527 out of 3,347) served nationally were referred for further assessment. Six regions--Regions V, VII, VIII, IX, X, and the IMPD projects--reported a much higher number of referrals than the average, with rates of 92%, 95%, 98% 100%, 97% and 95% respectively.

The majority (86%, or 2,175 out of 2,527) of children referred were Head Start enrollees. Eight regions reported that a majority of children referred were Head Start enrollees. Region VII had no children referred, however, and Regions V and IX reported only three each.

Selected Projects

Twelve projects reported that 79%, or 115 out of 150 Head Start children served, were referred for further assessment. Eugene had the highest number with 57, and Kingston was next with 17. All the non-Head Start children receiving nutritional services were referred, however.

Approximately 92% of the Head Start children referred were not previously enrolled, and all projects except Cleveland followed this pattern. The majority (62%) of these children, however, were Medicaid certified and most of the projects (eight out of 12) showed similiar results. El Centro, on the other hand, had all its Head Start children in this category as Medicaid Other.

Children Treated (E)

Aggregate Totals

A majority (59%, or 1,981 out of 3,347) of the children receiving nutritional services nationally were cited as treated and the preponderance of these were Head Start enrollees. For the selected projects, there were fewer children treated than those receiving nutritional services (45%).

Three regions--II, III, and VI--reported even higher rates of children treated than the national average at 87%, 78%, of 93% respectively. Three others--VIII, X and the IMPD projects--were much lower at 12% 11%, and 10%, respectively.

Selected Projects

Nine projects reported a total of 64 Head Start children treated. Cook County was highest with 19. Four out of the total of five non-Head Start children were reported as treated.

Most (85%) of the Head Start children were not previously enrolled and only 37% were Medicaid certified.

Cases Completed/Follow-Up Required (F & G)

Almost half (46%) of the children receiving nutritional services nationally had completed cases, a rate lower than that reported for mental health. The selected projects followed a similar pattern.

Region III had the highest rate of completion at 93% (11 out of 14) and Region II was the lowest at 7%. Region II, moreover, reported more non-Head Start cases completed. Obviously, the majority (56%) of cases required follow-up, however, Region VIII did report that all cases of non-Head Start children had been completed.

Selected Projects

Almost two thirds, 96 out of 150, of the Head Start children receiving nutritional services had completed cases. Again, most of this group (90 out of 96) were not previous enrollees, but in contrast to those treated, the majority (64%) were Medicaid certified. Four of the five non-Head Start cases were completed.

Almost all the Head Start children requiring follow-up were not previous enrollees but, interestingly, the majority (over 60%) were Medicaid Other.

2. Conclusions on Nutritional Services

- Head Start projects again this year reported fewer children receiving nutritional services, compared to medical, dental, and mental health services, reflecting either lower priority for this particular service or the lack of available resources. The percentage gain in children served was less than for the other services as well.
- Many more children receiving nutritional services were referred for further assessment within the Head Start program as compared to Head Start referral rates for other services.

3. Policy Considerations on Receipt of Dental, Mental Health and Nutritional Services

- Greater specificity regarding the kind of dental, mental health and nutritional services can yield information for descriptive analysis and future planning for health services in the Head Start program. Moreover, there is a need to assess the quality of health services and provider arrangements.

- The primary mental health services can be enhanced if Head Start programs are given technical assistance for the availability and applicability of various diagnostic and evaluative instruments. However, adequate assistance should also be provided to assure follow-up services (diagnosis and treatment) for those children who need them.

- Head Start development of nutritional services as a priority item can provide explicit recognition of the value of the program as a vehicle for ensuring adequate nutrition for pre-school children. Again, allocation of resources, including personnel, as well as greater utilization of USDA food programs can be of assistance in this regard.

Table XVI-E

NUTRITIONAL SERVICES BY AGGREGATED TOTALS

	A			B			C		
	CHILDREN PARTICIPATING CUMULATIVE			PREVIOUS NUTRITIONAL SERVICES			CHILDREN RECEIVING NUTRITIONAL SERVICES		
	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS
NATIONAL TOTALS	52,189	38,912	13,277	1,344	1,057	287	3,347	2,827	520
SELECTED PROJECTS	9,561	5,691	3,870	99	43	56	155	150	5
OTHER PROJECTS	42,628	33,221	9,407	1,245	1,014	231	3,192	2,677	515
REGION: I	4,566	2,444	2,122	106	35	71	234	118	116
II	4,368	2,636	1,732	158	46	112	252	58	194
III	2,810	2,410	394	75	63	12	14	8	6
IV	9,420	7,373	2,047	196	188	8	950	862	88
V	7,196	5,194	2,002	91	84	7	687	679	8
VI	13,119	12,178	941	443	439	4	569	557	12
VII	1,893	1,652	241	9	9	-0-	74	74	-0-
VIII	4,674	3,284	1,390	255	186	69	365	281	84
IX	694	567	127	1	1	-0-	25	22	3
X	3,449	1,168	2,281	10	6	4	177	168	9
*IMPD	1,887	1,139	748	210	164	46	350	280	70

* Not included in totals. Amounts are dispersed throughout the various regional totals.

NUTRITIONAL SERVICES BY AGGREGATED TOTALS

Table XVI-E (Continued)

	D			E			F			G		
	CHILDREN REFERRED FOR FURTHER ASSESSMENT			CHILDREN TREATED			CASES COMPLETED			CASES REQUIRING FOLLOW-UP		
	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS	1 TOTAL	2 HS	3 NHS
NATIONAL TOTALS	2,527	2,175	352	1,981	1,566	415	1,535	1,354	181	1,812	1,473	339
SELECTED PROJECTS	121	116	5	69	65	4	100	96	4	55	54	1
OTHER PROJECTS	2,406	2,059	347	1,912	1,501	411	1,435	1,258	177	1,757	1,419	338
REGION: I	132	49	83	208	94	114	122	90	32	112	28	84
II	164	49	115	229	45	184	18	7	11	234	51	183
III	9	5	4	11	5	6	11	6	5	3	2	1
IV	564	519	45	704	622	82	648	613	35	302	249	53
V	634	631	3	211	206	5	181	174	7	506	505	1
VI	399	393	6	532	525	7	193	189	4	376	368	8
VII	71	71	-0-	14	14	-0-	6	6	-0-	68	68	-0-
VIII	357	273	84	45	31	14	197	113	84	168	168	-0-
IX	25	22	3	12	10	2	10	9	1	15	13	2
X	172	163	9	15	14	1	149	147	2	28	21	7
*IMPD	333	263	70	30	30	-0-	182	112	70	168	168	-0-

* Not included in totals. Amounts are dispersed throughout the various regional totals.

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-E1 (Cont'd)

SELECTED PROJECTS BY STATE	B											
	CHILDREN RECEIVING PREVIOUS NUTRITIONAL SERVICES											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TOTALS FOR SELECTED PROJECTS	N/A	N/A	N/A	N/A	N/A	N/A	31	54	-0-	2	12	-0-
MASSACHUSETTS (I): Leominster	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	1	-0-
Worcester	N/A	N/A	N/A	N/A	N/A	N/A	1	-0-	-0-	-0-	-0-	-0-
NEW JERSEY (II): Trenton	N/A	N/A	N/A	N/A	N/A	N/A	2	-0-	-0-	-0-	1	-0-
Toms River	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	N/A	N/A	N/A	N/A	N/A	N/A	2	52	-0-	2	-0-	-0-
MARYLAND (III): Baltimore	N/A	N/A	N/A	N/A	N/A	N/A	1	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland												
TENNESSEE (IV): Kingston	N/A	N/A	N/A	N/A	N/A	N/A	1	1	-0-	-0-	1	-0-
ILLINOIS (V): Cook County	N/A	N/A	N/A	N/A	N/A	N/A	10	-0-	-0-	-0-	1	-0-
East St. Louis	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Danville	N/A	N/A	N/A	N/A	N/A	N/A	13	-0-	-0-	-0-	3	-0-
OHIO (V): Cincinnati												
Dayton												

N/A = Information Not Available

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVl-El (Cont'd)

SELECTED PROJECTS BY STATE	B											
	CHILDREN RECEIVING PREVIOUS NUTRITIONAL SERVICES											
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)		NOT MEDICAID CERTIFIED (5)		OTHER (6)	
	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS	a HS	b NHS
TEXAS (VI): Lubbock	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Amarillo	N/A	N/A	N/A	N/A	N/A	N/A	1	-0-	-0-	-0-	5	-0-
Laredo (IMPD)												
MISSOURI (VII): Springfield	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Appleton												
MONTANA (VIII): Billings	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Fort Peck (IMPD)	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro												
Fresno (IMPD)												
OREGON (X): Medford	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	N/A	N/A	N/A	N/A	N/A	N/A	-0-	-0-	-0-	-0-	-0-	-0-

N/A = Information Not Available

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-E1 (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN RECEIVING NUTRITIONAL SERVICES																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	9	-0-	-0-	-0-	9	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	6	-0-	-0-	-0-
Amarillo	10	-0-	-0-	-0-	10	-0-	2	-0-	-0-	-0-	2	-0-	-0-	-0-	6	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	2	-0-	-0-	-0-	2	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MONTANA (VIII): Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	7	-0-	-0-	-0-	7	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-	5	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-o-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	7	-0-	2	-0-	5	-0-	7	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	57	-0-	-0-	-0-	57	-0-	48	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-E1 (Cont'd)

SELECTED PROJECTS BY STATE	C																	
	CHILDREN RECEIVING NUTRITIONAL SERVICES																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	150	5	15	-0-	135	4	87	2	-0-	-0-	5	-0-	1	-0-	57	2	-0-	-0-
MASSACHUSETTS (I): Leominster	3	2	-0-	-0-	3	1	2	1	-0-	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-
Worcester	3	-0-	-0-	-0-	3	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
NEW JERSEY (II): Trenton	6	2	-0-	-0-	6	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	2	-0-	-0-
Toms River	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	7	1	4	-0-	3	1	3	1	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
TENNESSEE (IV): Kingston	18	-0-	3	-0-	15	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	16	-0-	-0-	-0-
ILLINOIS (V): Cooks County	19	-0-	5	-0-	14	-0-	9	-0-	-0-	-0-	1	-0-	-0-	-0-	8	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	1	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-E1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN REFERRED FOR FURTHER ASSESSMENT																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	116	5	10	-0-	106	5	73	2	-0-	-0-	4	-0-	1	-0-	39	2	-0-	-0-
MASSACHUSETTS (I): Leominster	3	2	-0-	-0-	3	2	2	1	-0-	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-
Worcester	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
NEW JERSEY (II): Trenton	6	2	-0-	-0-	6	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	2	-0-	-0-
Toms River	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	5	1	4	-0-	1	1	3	1	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
TENNESSEE (IV): Kingston	17	-0-	3	-0-	14	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	15	-0-	-0-	-0-
ILLINOIS (V): Cooks County	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	1	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XV1-E1 (Cont'd)

SELECTED PROJECTS BY STATE	D																	
	CHILDREN REFERRED FOR FURTHER ASSESSMENT																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	3	-0-	-0-	-0-	3	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Amarillo	6	-0-	-0-	-0-	6	-0-	1	-0-	-0-	-0-	2	-0-	-0-	-0-	3	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-		-0-	-0-	-0-
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	2	-0-	-0-	-0-	2	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MONTANA (VIII): Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	7	-0-	-0-	-0-	7	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-	5	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	7	-0-	2	-0-	5	-0-	7	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	57	-0-	-0-	-0-	57	-0-	48	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN
BY SELECTED PROJECTS

Table XVI-E1 (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CHILDREN TREATED																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	b	c		Non-HS a	b	c		Non-HS a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	65	4	11	-0-	54	4	25	2	-0-	-0-	2	-0-	-0-	-0-	37	2	-0-	-0-
MASSACHUSETTS (I): Leominster	-0-	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0	-0-	-0-
Worcester	3	-0-	-0-	-0-	3	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
NEW JERSEY (II): Trenton	6	2	-0-	-0-	6	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	2	-0-	-0-
Toms River	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MARYLAND (III): Baltimore	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSISSIPPI (IV): Cleveland	3	1	1	-0-	2	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0-
TENNESSEE (IV): Kingston	14	-0-	3	-0-	11	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	13	-0-	-0-	-0-
ILLINOIS (V): Cooks County	19	-0-	5	-0-	14	-0-	9	-0-	-0-	-0-	1	-0-	-0-	-0-	8	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	1	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-El (Cont'd)

SELECTED PROJECTS BY STATE	E																	
	CHILDREN TREATED																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c Oth.	HS	a Sib.	b Non-Sib.	c
TEXAS (VI): Lubbock	8	-0-	-0-	-0-	8	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	5	-0-	-0-	-
Amarillo	8	-0-	-0-	-0-	8	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	6	-0-	-0-	-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Appleton	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
MONTANA (VIII): Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
CALIFORNIA (IX): El Centro	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Fresno (IMPD)	-0--	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
OREGON (X): Medford	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-E1 (Cont'd)

SELECTED PROJECTS BY STATE	F																	
	CASES COMPLETED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	96	4	6	-0-	90	4	65	1	-0-	-0-	4	-0-	1	-0-	24	2	-0-	-0-
ASSACHUSETTS (I): Leominster	2	1	-0-	-0-	2	1	2	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-
Worcester	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
EW JERSEY (II): Trenton	6	2	-0-	-0-	6	2	4	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	2	-0-	-0-
Toms River	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
ARYLAND (III): Baltimore	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
ISSISSIPPI (IV): Cleveland	4	1	3	-0-	1	1	3	1	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
TENNESSEE (IV): Kingston	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-
LLINOIS (V): Cooks County	5	-0-	1	-0-	4	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
HIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-E1 (Cont'd)

SELECTED PROJECTS BY STATE	F																	
	CASES COMPLETED																	
	TOTAL		PREVIOUSLY ENROLLED		NOT PREVIOUSLY ENROLLED		MEDICAID CERTIFIED				NOT MEDICAID CERTIFIED				OTHER			
								Non-HS				Non-HS				Non-HS		
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	6	-0-	-0-	-0-	6	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	-0-	-0-	-0-
Amarillo	5	-0-	-0-	-0-	5	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	4	-0-	-0-	-0-
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Appleton	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
MONTANA (VIII): Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
CALIFORNIA (IX): El Centro	4	-0-	-0-	-0-	4	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0-	3	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	5	-0-	1	-0-	4	-0-	5	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	57	-0-	-0-	-0-	57	-0-	48	-0-	-0-	-0-	-0-	-0-	-0-	-0-	9	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-E1 (Cont'd)

SELECTED PROJECTS BY STATE	G																	
	CASES REQUIRING FOLLOW-UP																	
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	b	c		Non-HS a	b	c		Non-HS a	b	c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TOTALS FOR SELECTED PROJECTS	54	1	9	-0-	45	1	20	1	-0-	-0-	2	-0-	-0-	-0-	31	-0-	-0-	-0
MASSACHUSETTS (I): Leominster	1	1	-0-	-0-	1	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0
Worcester	3	-0-	-0-	-0-	3	-0-	3	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
NEW JERSEY (II): Trenton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Toms River	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	-0-	-0-	-0
Paterson	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MARYLAND (III): Baltimore	-0--	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MISSISSIPPI (IV): Cleveland	3	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	3	-0-	-0-	-0
TENNESSEE (IV): Kingston	17	-0-	2	-0-	15	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	15	-0-	-0-	-0
ILLINOIS (V): Cooks County	14	-0-	4	-0-	10	-0-	7	-0-	-0-	-0-	1	-0-	-0-	-0-	5	-0-	-0-	-0-
East St. Louis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Danville	1	-0-	1	-0-	-0-	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OHIO (V): Cincinnati																		
Dayton	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-

NUTRITIONAL SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY SELECTED PROJECTS

Table XVI-E1 (Cont'd)

SELECTED PROJECTS BY STATE	G																		
	CASES REQUIRING FOLLOW-UP																		
	TOTAL (1)		PREVIOUSLY ENROLLED (2)		NOT PREVIOUSLY ENROLLED (3)		MEDICAID CERTIFIED (4)				NOT MEDICAID CERTIFIED (5)				OTHER (6)			
								Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c		Non-HS a	Non-HS b	Non-HS c
	HS	NHS	HS	NHS	HS	NHS	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.	HS	Sib.	Non-Sib.	Oth.
TEXAS (VI): Lubbock	3	-0-	-0-	-0-	3	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0
Amarillo	5	-0-	-0-	-0-	5	-0-	2	-0-	-0-	-0-	1	-0-	-0-	-0-	2	-0-	-0-	-0
Laredo (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MISSOURI (VII): Springfield	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Appleton	1	-0-	-0-	-0-	1	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
MONTANA (VIII): Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Fort Peck (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
Blackfeet (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0
CALIFORNIA (IX): El Centro	3	-0-	-0-	-0-	3	-0-	1	-0-	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Fresno (IMPD)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OREGON (X): Medford	2	-0-	1	-0-	1	-0-	2	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Eugene	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0	-0	-0-	-0-	-0-	-0-	-0-

VII. HEAD START/EPSDT RELATIONS WITH LOCAL, STATE, AND FEDERAL AGENCIES AND ANALYSIS OF HEAD START PROGRAM PERFORMANCE STANDARDS AND STATE EPSDT PLANS

Introduction

This section presents a comparative analysis of the relationships between the Head Start program performance standards and state EPSDT plans as well as relationships between the selected projects and local, state and federal agencies within the context of the EPSDT institutional framework. The analysis that was presented in the Interim Report on state EPSDT plans and providers' attitude is summarized, and those tables are included in Appendix A. The comparative analysis of the performance standards and the EPSDT plans of the target states is shown on Table X-A of this report.

NOTE: Data in Table X has been further analyzed since the interim report. The results of this further analysis are shown in the table included in Appendix A of this report.

A. COMPARISON OF HEAD START PERFORMANCE STANDARDS AND STATE EPSDT PLAN (TABLE X-A)

This section presents a comparative analysis of the Head Start Performance Standards and the EPSDT plan of each of the target states.* The guidelines of the collaborative effort stipulated that the Head Start projects were required to provide certain minimum health services in accordance with the Performance Standards regardless of the scope of state EPSDT plan. An analytic task for the evaluation was, therefore, to take into account the extent to which services required of Head Start were provided/obtainable under the various state plans.

In order to measure the cost impact of the demonstration program, documentation regarding the extent to which services required by Head Start were in fact EPSDT reimbursable was needed, as well as whether any limitations were placed against the provision or reimbursement of these services. A comparison of the Head Start Performance Standards and the state EPSDT plans by the provision of services (Head Start and EPSDT), reimbursement available through EPSDT, and limitations is presented in Table X-A.

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* The presentation of the findings is based on the analysis of the plans of all target states except Maryland for which we were unable to obtain written policy regarding the health services package.

Background

Head Start Performance Standards

In 1973 the Office of Child Development* issued the Head Start Performance Standards as a measure of strengthening the quality of services provided to children and families served by Head Start. The standards established national criteria for performance and built upon seven years' experience of the Head Start program as a demonstration effort. As such they reflected the programmatic concerns of OCD, and provided for quality control in the provision of comprehensive services for children to attain optimal cognitive, emotional, social and physical growth.

Although local initiative has been encouraged, Head Start grantees are required, as a condition of funding, to meet the minimum standards set forth in education, social services, parent involvement, and health services including medical, dental, mental health and nutrition.

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*In June 1975 the Office of Child Development published the revised Performance Standards which became effective July 1, 1975. However, the standards in effect during the first year of the collaboration were those set forth in OCD Notice N-30-364-1-00. It is this series that was used for the comparison with the state plans.

Requirements of State Medicaid/EPSDT Plans

The regulations issued by SRS in November 1971 for EPSDT mandated state Medicaid plans to provide screening and diagnosis services, and treatment of medical problems thus detected, within the limits and scope of the state plan. Furthermore,these services were to be available to all eligible individuals under 21 years of age. However SRS regulations for EPSDT only set forth recommended standards for the screening programs and did not specify screening procedures. The state Medicaid plan was required to specify the content of the screening package and maintain written evidence of such specification. In addition, the Federal regulations allowed states to define "early" and "periodic" thus affecting the frequency by which children received services. During the first year of the collaboration, a minimum package of screening procedures was not mandated. SRS, however, has been conducting a series of consultations with child health authorities to determine whether a minimum package of screening procedures should actually be required.

The EPSDT regulations do not serve as national standards for child health services. Rather they, allow for standard-setting at the state level. Enforcement therefore is limited to the provision of services specified in the state plan. Even when individual states specify particular screening units, there is often a wide variation in the type of service rendered due to lack of specification of screening instruments and procedures.

Methodology

The Head Start Performance Standards present an interdisciplinary approach to health services as a means of improving the physical, mental and nutritional status of preschool children. Moreover, the standards require that the local Health Advisory Committee, composed primarily of parents of Head Start children, be established to assist in planning and evaluating the health program. However, the Policy Council (the parent involvement body) must approve the program.

As part of the methodology used in the comparative analysis of the Head Start Performance Standards and the state EPSDT plans, a review was made of the standards to establish categories of service provisions most applicable to the actual delivery of health services. Standards calling for such activities as the Health Advisory Committee and the Health Program Assessment Report were not used to assess comparability, for these were assumed to be program responsibilities unique to Head Start. Related categories to those activities, however, were established such as provisions for recordkeeping and consumer/ parent involvement.

In addition, certain activities were clustered and redefined. For example, since Head Start staff are involved with children on a daily basis, some required activities differ from those expected of a provider whose contact is on an intermittent basis.

The requirements of the nutritional program are illustrative, for not only are programs required to perform nutritional assessments and educational activities, but also, they must provide nutritional meals and snacks daily. Therefore, for the purposes of analysis, the nutritional program was clustered into activities of nutritional assessment and nutritional education.

Thus, establishing the Head Start Performance Standards as a baseline, the EPSDT plans for the target states were examined to determine their comparability with these standards. The analysis concentrated on written policy either in the form of manuals or an actual state plan; the rationale being that such documents represented the formal policy to which agencies such as Head Start might have greater access because of their availability as public records. In addition, the presentation of the written policy will help Head Start programs become familiar with the EPSDT services that should be available and thereby press for their actual provision.

Although Montana had not published a state plan, information on the operational aspects of the program was abailable in the form of the EPSDT Penalty Reporting Form, and the written contracts between Montana's State Department of Social and Rehabilitation Services and the State Department of Health and Environmental Sciences, and the health department's subcontractors.

These documents describe the requirements of the screening packages, and it is in this form that Montana's data is presented.

1. Analysis of Findings

Health Services

History (medical and developmental). All eleven states required that a history of the child be obtained. However, the type and level of specificity varied with state requirements, ranging from recommending that a "brief history" be gathered to requiring detailed histories with specification on the permanent medical record. Texas, for example, required that a complete history for birth, prior hospitalization, allergies, bedwetting, bowel habits be recorded. On the other hand, Montana required only that a medical history be obtained and Mississippi and New Jersey required that a history with no differential between medical and developmental information.

The implications of the variance is that states in which itemized histories were required, particularly if completion of this detailed history were required on the reporting form, insured that the provider was obtaining a comprehensive history on the child. This in turn might have better enabled the provider to assess the child's current health and identify possible medical problems. States which required only a "brief history" allowed the practitioner to determine which if any aspects of the child's history would be obtained. Therefore, different levels and quality of care most likely were rendered relative to the professional concern of the attending practitioner.

Screening. The Head Start Performance Standards presented a list of screening tests and procedures to be given to all children in order to assess each child's mental and physical health. All the states provided for the basic screening services of growth assessment, vision and hearing testing, and assessment of immunization status. However, the provision of many of the other screening tests was affected by the inclusion of some procedures as optional or recommended only"if indicated"in several states. In New Jersey,Missouri and Ohio,for example, a tuberculin test was not required and this procedure was performed only if indicated. In addition, Ohio and New Jersey required hemoglobin/hematocrits only if indicated, and New Jersey did not require urinalysis except where indicated. The conditions whereby these procedures would be indicated were not specified. Again, this failure to specify allowed a great deal of discretion to local practitioners to include such procedures.

Examination of the provisions for vision and hearing tests revealed an interesting pattern. Only Tennessee, Mississippi, Montana, Texas and Oregon stated the specific screening procedures to be used (e.g., titimus Telobinocular, or Pure Tone audiometer). The other states merely specified that vision and hearing tests be performed, which might vary from a visual inspection of the eyes to a comprehensive examination. All states,except Montana, required sickle cell screening, with New Jersey, Ohio and California qualifying that the screening be performed "as indicated."

Other areas of selected screenings were: six states required lead poisoning screening, and three additional states (California, Oregon and New Jersey) required it only if indicated, Two states, Mississippi and Montana, made no provision for lead poisoning screening. Four states, New Jersey, Mississippi, Tennessee and Ohio, make provision for intestinal parasites screening where indicated. This pattern may, however, have reflected the prevalence rates of such problems in various regions. Oregon, Montana, Tennessee, Ohio and Texas made provision for the identification of speech problems. California was the only state which specified the identification of handicapped children. Massachusetts reported exploring the possibility of using its Department of Public Health as an outreach mechanism for those Medicaid eligible children with special needs.

Physical Examinations. The itemization of the physical examination required in the Performance Standards varied from one state to another. For example, New Jersey and Montana required only a physical examination while in Mississippi and California, the physical examination mandated was identical to the Head Start Performance Standards. Of the remaining states, the most commonly mentioned items were examination of ears, eyes, nose and throat.

Immunizations. All states required an updating of immunizations. Neither Missouri, Massachusetts, nor New Jersey, specified the required immunizations. Mississippi required these services pursuant to the policies of the Board of Health, but such policies are not specified. Two states, Tennessee and Illinois, did not reimburse for immunization against mumps. Ohio, Texas and Massachusetts did not specify immunizations in the narrative of the state plan, but they are reflected in the reporting form and other documents included in the plan.

Nutritional Assessment. All the states with the exception of New Jersey and Illinois made some provision for nutritional assessments. This ranged from a state plan recommending examination of the skin, " which may be of nutritional significance," or anemia testing, to requirements for a detailed examination of a child's dietary habits. No states except Mississippi specified plans for nutritional education/counseling.

Dental Screening. All states provided for dental screening which varied between states in the level of specificity. Some states merely required a "dental screening" or an examination of teeth and gums, whereas others called for thorough examinations, including bite-wing x-rays and prophlaxsis. For dental care, the general pattern was to categorize services into the areas of preventive and emergent/therapeutic. Many states did not require that the dental screening be performed by a dentist, and in some states such as Tennessee, a child had to be screened through the Medicaid program before a referral could be made for dental treatment. None of the states except Tennessee defined the dental screening package identical to the Performance Standards. Rather, many states provided only a dental screening under the EPSDT state plan. If treatment was required, the child was referred and additional services were covered under the general Medicaid program. New Jersey and Massachusetts did not outline a treatment program; but Massachusetts reported it was in the process of developing sound dental referral mechanisms. California only mentioned that children be referred for therapeutic attention. A prevalent trend in the area of dental services was the requirement of prior authorization for dental treatment, although this was not true for dental diagnosis and further assessment in Oregon, Missouri (for some services), Tennessee and Mississippi.

The periodicity of dental services differed among state plans. Massachusetts and Ohio provided for dental screenings every six months. Texas performed dental screening every three years unless otherwise requested by the parents.

Dental reimbursement patterns varied and many states did not specify the billing procedure or reimbursement rate. Others specified maximum limits (i.e., Mississippi $100/child/year) and Tennessee required prior authorization for treatment plans totaling more than $60. States, such as Texas, reimbursed according to usual and customary fees. Oregon's plan contains a fee schedule. A complete analysis of the dental reimbursement and treatment provisions was not possible because most of the state plans failed to indicate specific treatment and reimbursement procedures.

Treatment. Examination of provision for treatment requirements revealed no uniform pattern. In part, this reflected of the organization and administration of the State EPSDT plan. For example, in Illinois, the screening package was provided for under the Medicheck program (with separate billing and recordkeeping requirements). However, if treatment was deemed necessary, it was provided for and billed to the general Medicaid program. Although this was an administrative division of labor and responsibilities, it complicated the procedure for providers and organizations such as Head Start in their understanding of the program. In addition, states which provided screening through screening clinics(i.e., Texas) referred patients to other providers for diagnosis and treatment, (i.e., traditional providers such as private practitioners). In this case billing and reimbursement was administered through the current health insurance contract between the Department of Public

Welfare and Group Hospital Services. Texas and Ohio were the only states which listed the porvisions of their treatment package; however, this was in a general manner. Most of the EPSDT plans did not itemize the benefit package for treatment services.

California's Child Health Disability Prevention Program was limited to screening and those children in need of treatment were referred to the Medi-Cal program. This new program supplanted the EPSDT program in the state and provided for early and periodic screening of all Medi-Cal eligible children as well as those entering the first grade whose gross annual family income was at or below twice the AFDC minimum base. However, Medi-Cal recipients in need of diagnostic and treatment services were referred to the state Medicaid program. The details of the treatment package were not itemized.

Provision for Annual Assessment. All states except Mississippi mentioned provision for periodic assessment, although the definition of this term differed greatly. Several states called for annual assessments regardless of age (New Jersey, Missouri and Illinois). Tennessee, Oregon, California and Massachusetts developed a visit schedule by age of intervals when a child should be screened. As another example, Massachusetts provided for visits at 2-6 weeks, 8-10 weeks, 4 months, 6 months, 9 months 1 year 1 1/2 years, yearly 2-6, 8 years and 10 years. Ohio authorized screening at ages 1, 4, 7, and 16.

Texas provided for annual assessment for children under six and every three years from 6-21. Mississippi did not specify a plan for periodic assessment.

Mental Health Consultation. Although many of the states mentioned the importance of uncovering physical and mental defects, only the following specified some provision for the availability of mental health consultation.

Oregon is the only state which made provision for mental health referral/treatment and prior authorization was needed before treatment could begin. California provided for referral for "mental health conditions " (such as mental retardation) uncovered in screening. Illinois provided space for mental development assessment on the billing form; however, the manual text did not detail the provision of such services. Moreover, it seemed likely that this service could be interpreted as a developmental assessment and as such is not reflected on the table. Mississippi mentioned that mental health facilities were available for neurological/developmental referrals. Montana provided for psychological testing if indicated. Within the area of mental health an interesting trend was observed. All of the states made provision for developmental assessments. Texas, Oregon, California, and Montana all recommended that the Denver Developmental Screening test be the instrument for evaluating the children.

Supportive Services and Other Related Activities

In general, the specification for supportive services seemed to be the least well defined. Although many state plans stated the importance of providing services such as health education, they did not set forth the particular aspects for such a program.

Health Education. Provisions for health education activities were generally limited. In most instances, health education was not identified as a distinct program activity; rather, it was included as a component of outreach and recruitment. These activities were generally limited to orienting and educating the parents to the availability and value of screening and other preventive measures as a part of recruitment for EPSDT participants. Generally such activities were the responsibility of the public welfare case workers. California, Tennessee, Ohio, and Texas made such recruitment health education provisions. In many cases, the operational aspects of the program were limited to flyers, recruitment leaflets and public broadcasting spots. However, other states such as New Jersey used similar recruitment procedures but did not categorize the activity as health education. As such, this is not reflected in the table. California specified that health education not be limited to simple notification, but should be designed to enable eligibles to participate as informed consumers. Illinois suggested a health education program in the areas of preventive health care, physical and emotional development, and accident and poison prevention. In addition some states required that families be counseled, and that test results be interpreted to the parents.

Recordkeeping. The provision for recordkeeping and the accessibility of information on the health status of individual children was another issue area for analysis. All states made some provision for recordkeeping, with specific reference to the maintenance of records by individual child. A common pattern was to require a record of screening procedures and/or results on the invoice or billing form (Texas, Illinois, Missouri, New Jersey, Ohio and Oregon). This procedure aided states in complying with federal reporting requirements.

The required level of detail in reporting, however, varied. Some reporting forms provided space to indicate that hematocrit had been measured. Other forms required actual reporting of the specific level. In addition, some states required that the individual units of screening performed be reported to the state. Others only required providers to report that screening had been provided and to itemize the conditions uncovered. Some reporting systems required that records be maintained by providers without specification regarding the form that records should be maintained. No state made provision for forwarding the child's record to a school system. Many specified that the child's parents be informed of the test results and in some states parents were given a copy of the screening and immunization record.

State policies regarding the recording of health information and its release may have presented difficulties for Head Start projects, because data was not always retrievable or available in a form suitable to Head Start. In states where individual providers maintained the child's record, negotiations would have been necessary to secure release of information. In states with centralized records on each child, recordkeeping procedures or requests for information might have been less cumbersome.

Confidentiality. All states except Mississippi and Illinois addressed the importance of confidentialty. Most attempted to sensitize staff and providers to the importance of this issue, and encouraged respect for the privacy of the client.

Parental Consent. All states did not specifically address the issue of parental consent although it seemed that such provisions would have been covered under other state laws relating to the provision of treatment to minors. California, Montana, Ohio, Texas and Tennessee did make specific reference to this issue. However, parental consent was not specifically addressed in the remaining plans.

Parent Involvement/Consumer Participation. California was the only state which provided for parent involvement in the local child health services system.

The regulations for the development of the local Child Health and Disability Program provided for non-professional consumer involvement and parent representation on local advisory boards. The functions of this board included review of the community's child health needs, adequacy of health care providers, and review of the child health and disability plan. The board could advise the governing board, and establish committees as it deemed necessary to fullfull its purposes. Due to the rather liberal eligibility requirements of the program, parents of children who were eligible for the child health disability prevention program but not Medi-cal could also serve on the board.

Staff Examination. None of the EPSDT plans made provision for health examinations and periodic check-ups of staff members. This finding highlighted the difference between the responsibilities and level of involvement of Head Start personnel who had daily contact with the children and state and local welfare, special services staff and providers whose contact was intermittent.

Staff Training Orientation (Including program vendors' providers). Only five states included provision for staff or provider training/orientation in the state plan. In general, this seemed to be limited primarily to basic orientation of the staff on the purpose and details of EPSDT in order that they would perform their outreach/recruitment functions more effectively. Some states provided orientation only through physicians(e.g., letters and other descriptive material to enlist their cooperation in the program).

New Jersey set forth the most specific staff training program, which consisted of a series of sessions on the complexities of the EPSDT program and its purpose and value, the recordkeeping and referral systems, procedures for eligibility determination and delineation of professional staff responsibilities. In addition, some of the state manuals or plans served as instructional documents in themselves because they detailed the screening package and provided "how-to" instruction on performing certain procedures. In some states, the majority of training focused on the administrative procedures of case-finding, billing procedures and data collection/retrieval. Some states (Texas, for example) required the training of personnel who performed specific procedures, such as vision and auditory screening.

The importance of adequately trained staff was highlighted by the finding of the compliance review of EPSDT in Montana*. It was reported that staff responsible for recruitment and outreach lacked an understanding of the screening program, and that many believed it was a one-time activity, while others felt it was a program of the State Health Department.

Provision for Coordination and Linkage. The level and degree of interagency agreement for providing EPSDT services in coordination with other community agencies was a critical area for analysis because of its significance to the collaboration effort. The predominant mode of coordination existed among levels of state or local units of government rather than agreements with other community agencies. (Table XII describes these various levels of agreement).

Several states stressed the importance of linkage and coordination with existing community resources. Specifically, Massachusetts and New Jersey mentioned the OCD demonstration effort and the potential for collaboration and Ohio mentioned the possibility of using existing resources, such as Head Start for the delivery of EPSDT services. California mentioned the value of coordination because it did not wish to supplant existing resources. The Montana EPSDT compliance review reported that differences existed between policies of the Indian Health Service and county welfare staff and recommendations were made that the two programs explore coordination of their activities. Missouri reported that the state was using outpatient department and OEO clinics, and was exploring the possibility of using data generated from Health Start health records. Negotiations were reported to be underway with existing maternal and child health programs.

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*Source: Early and Periodic Screening, Diagnosis and Treatment Penalty Reporting Form, Montana, November 12, 1974.

Oregon did not specify activities for coordination and linkage. However, its vendor eligibility requirements allowed for the involvement of a wide variety of community resources such as Head Start. Mississippi referred children to existing community agencies and suggested Head Start as a potential referral for certain services such as psychological testing. However, the specificity of such arrangements and the levels of responsibility were generally not discussed. Thus the provision for linkage and coordination was presented as a recommendation rather than as a detailed, well organized plan.

The Head Start Performance Standards provided for linkage and coordination to enable children and their families to be aware of and utilize all resources which might be available to them. In part this was to insure that parents were aware of other resources so that they could continue to receive services after the child had left the Head Start program. As Table XII reveals, state agencies tended to make the greatest number of contractual or cooperative arrangements in the area of health services. There were many fewer arrangements for supportive services. Possibly, programs such as Head Start are viewed by state EPSDT agencies as providers of supportive rather than medical services, and thus states have not fully explored their potential.

Reimbursement and Limitation. The restrictions on vendor status in the overall Medicaid program and further limitations or requirements imposed by the EPSDT plan are presented later in the report. (See Tables XI-D and XIII.) The implications of these policies for Head Start, in terms of receiving vendor status are discussed. For purposes of this analysis, the data was reviewed in relation to the extent that EPSDT reimbursement policies impact on the ability of Head Start programs or their providers to receive reimbursement for services provided either directly or indirectly, i.e., Medicaid reimbursing Head Start or Medicaid paying for services required by the performance standards.

Most states reimbursed at a fixed fee for the total screening package, as in Missouri, Tennessee, Mississippi and Montana. Tennessee provided additional remuneration for diagnostic visits, while Missouri provided a fixed fee for lab tests and immunizations. California, Oregon and Massachusetts reimbursed a fixed fee for the health visit and assessment, but, in addition, reimbursed for the individual units of screening and additional tests. In Massachusetts practitioners were not reimbursed for immunization, tuberculin tests or vision screening, for these elements were included in the fee of $15 for the comprehensive visit. However, other tests and procedures such as hematocrit, hearing test by audiogram, urinalysis, and all laboratory tests and optional exams such as Denver Developmental, blood lead, sickle cell, and puretone audiometer were reimbursed. New Jersey reimbursed specialists and generalists at different rates with a comprehensive fee and in addition reimbursed the practitioner for certain laboratory tests performed in the office. Since biologicals were provided by the state, no reimbursement was made for immunization.

The Ohio state plan provided no information on its reimbursement policy. Texas claimed to pay actual costs through a contractual arrangement with the state health department but details of such arrangements were not presented. Therefore, no information is presented on the table for these states. Montana contracted with the Department of Health and Environmental Sciences on a capitation basis and this agency in turn subcontracted health assessments at $10/child. Illinois restricted reimbursement for specific services--vision and hearing--for they were provided by the Illinois Board of Health and reimbursement was not granted to any other provider. In addition, some states restricted the provision of some services, for example, only reimbursing for sickle cell screening once. In New Jersey reimbursement was provided for a microscopic urinanlysis but not for a 4-test dipstick. Oregon required prior authorization for treatment of dental conditions, psychotherapy and speech therapy.

The above findings suggest that when providers are reimbursed for individual procedures, the children are more likely to receive all services, some of which are ignored when practioners are reimbursed for a package.

In terms of any future attempts by Head Start projects to receive direct reimbursement, Head Start projects might not be able to receive vendor status unless they could provide the entire screening package, particularly in those states which pay for only the entire screening package. However, in states that itemize payment for specific services, Head Start projects might possibly be able to negotiate for payment of services they provide, such as Denver Developmental Screening tests, vision and hearing, tubercular test and immunizations. In addition, many projects reported performing various aspects of the screening package (for example, TB test, growth assessment, medical history, vision, hearing tests, developmental assessment, etc.) for the practitioner; possibly Head Start could be reimbursed for services provided for providers.

Analysis of the plans suggests that other restrictions and regulations, such as prior authorization, might complicate or prevent Head Start from maximizing on the resources of EPSDT or obtaining third party reimbursement for services rendered to their eligible children during the program year.

2. Conclusions on Head Start Performance Standards and State/EPSDT Plans

a. In general the performance standards and the state plans cover the same basic provisions. However, there is a substantial non-conformity in the level of specificity for such services. For example, although all states provide for a basic physical examination, only two states require the exact same level of detail as do the Performance Standards; and 3 of the states do not specify the required immunizations.

- Although treatment was provided under all plans, specification of the benefit package was not uniform, and often was not presented in the state plans. Head Start requires treatment for all detected problems. However, given the nature of Head Start as a multi-disciplinary child development program a high level of detail on the components of the treatment package was not expected. The EPSDT plans, which are specifically concerned with child health, tended to focus more on the provision of screening services and did not itemize treatment; rather, they promoted screening children through access to the Medicaid program or treatment through the EPSDT screening. This complicates the collaboration process for an agency such as Head Start and necessitates a state by state analysis of treatment provisions.

- Dental services were generally defined in general terms and categorized around preventive and emergent/therapeutic services. Even in states with detailed plans the dental services were not well specified and the operational aspects of the program were not fully presented.

b. The content of state EPSDT plans tended to focus on the administrative aspects of the program (billing procedures, eligibility requirements, fiscal arrangements) rather than upon support services such as health education, staff training, or coordination of community resources. This pattern is reinforced by the reimbursement policies which do not reimburse for such services,but rather reimburse for specific medical or dental services. Other conclusions in the area of support services are:

- There is no uniformity in the maintenance of records across states. In addition, the data collection and reporting systems required by the states might not be compatible with Head Start's data needs.

- The lack of provision for consumer participation in the state plans is an example of the discrepancies between the respective mandates of Head Start and EPSDT agencies. Head Start insists on involving program recipients in the planning and monitoring of the program. Only one state, California, makes provision for consumer involvement.

- As reflected in the state plans, health education activity is more directly tied into the outreach/recruitment aspects, rather than an ongoing program of health education activities.

c. Only five of the plans mention provision for linkage and coordination with other community resources, and this was presented in general terms. States did not present formal, detailed plans or guidelines on how coordination or linkage of projects for efficient delivery of services might be operationalized.

3. Policy Considerations on Head Start Performance Standards and State/EPSDT Plans

a. The differing levels of specificity and precision in defining the benefit package across state plans will probably limit Head Start's ability to entrust provision of required services to the EPSDT program, for the programmatic concerns of each program differing. In addition, there are differences across states in the services mandated and the delivery modes employed. This is not surprising because the EPSDT plans do not reflect national standards. In general child health programs have no uniform or minimum enforceable standards. Children who access into the health delivery system from various points receive different types of services. A policy of minimum national standards for all child health programs, regardless of the point of access, might be taken into consideration.

b. Child human service programs do not always provide for consumer participation mechanisms to allow the consumers a say in the planning and development of services designed for their benefit. Study might be undertaken to examine the importance and effect of consumer involvement in child health programs.

c. A lack of provision for coordination and linkage is evidenced in many of the state plans, and is symptomatic of the limited development and exploration of such arrangements between Medicaid agencies and provider and user agencies in the respective states.

d. Policy analysis might be undertaken to investigate ways to better implement mechanisms for coordination and linkage of agencies serving similar target groups.

4. Conclusions on State EPSDT Plan for Target States *

a. The states' definitions of service tended to provide for those functions which are particular to the EPSDT program, i.e., early, periodic, screening. Those functions which are more traditional or universally provided by health and social service systems such as diagnosis, treatment supportive services and outreach were generally not clearly defined by the states.

b. All states except Montana provided for follow-up recordkeeping. In the majority--five of the states--the EPSDT unit retained operational responsibility for this function. Four states delegated operational responsibility for follow-up recordkeeping to a governmental agency other than the EPSDT unit, and one state utilized the services of a private insurance company. Eight states had computerized recordkeeping systems and three, including Montana, maintained their data manually.

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*These conclusions are based on data from Table X, which is included in Appendix A.

HEAD START PERFORMANCE STANDARDS	TARGET STATES																	
	Mass.			N.J.			Md.			Miss.			Tenn.			Ill.		
A. HEALTH SERVICES	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
History				Y	CF					Y	CF							
medical	Y	CF											Y	CF		Y	CF	
developmental	Y	CF											Y	CF		Y	CF	
Screening																		
growth assessment	Y	CF		Y	CF					Y	CF		Y	CF		Y	CF	
vision testing	Y	CF		Y	CF					Y	CF		Y	CF		Y	NR	Y
hearing testing	Y	R		Y	CF					Y	CF		Y	CF		Y	NR	y
hemoglobin-hematocrit	Y	R		II	R					Y	CF		Y	CF		Y	R	
tuberculin	Y	CF		II	NR					Y	CF		Y	CF		Y	R	
urinalysis	Y	R		II	R	Y				Y	CF		Y	CF		Y	R	
assess immunizations	Y	CF		Y	CF					Y	CF		Y	CF		Y	CF	
(if appropriate)																		
sickle cell	Y	R		II	R					Y	CF		Y	CF		Y	R	
lead poisoning	Y	R		II	R								Y	CF		Y	R	
intestinal parasites				II	R					Y	CF			II				
I.D. of speech problems													Y	CF				
I.D. of needs of the handicapped																		
Physical Examination	Y	CF		Y	CF					Y	CF		Y	CF		Y	CF	
ear	Y	CF								Y	CF		Y	CF				
skin										Y	CF		Y	CF				
eyes	Y	CF								Y	CF		Y	CF				
nose	Y	CF								Y	CF		Y	CF				
throat	Y	CF								Y	CF		Y	CF				
heart	Y	CF								Y	CF							
groin										Y	CF		Y	CF				
Completion of Immunizations	Y	CF		Y	CF					Y	CF		Y	CF		Y	CF	
diptheria													Y	CF		Y	CF	
pertussis													Y	CF		Y	CF	
tetanus													Y	CF		Y	CF	
polio													Y	CF		Y	CF	
measles													Y	CF		Y	CF	

SEE NEXT PAGE FOR CODES

TABLE X-A (Cont'd.)

HEAD START PERFORMANCE STANDARDS	TARGET STATES																	
	Mass.			N.J.			Md.			Miss.			Tenn.			Ill.		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
german measles													Y	CF		Y	CF	
mumps													N			N		
Nutritional Assessment	Y	CF								Y	CF		Y	CF				
Nutritional Counseling/Education										Y	NS							
Dental Screening:	Y	NS		Y	CF					Y	CF		Y	R		Y	R	
prophylaxis & oral hygiene education													Y	R				
fluoride application													Y	R		Y	NS	
Dental Treatment				Y	NS					Y	R	Y	Y	R	Y			
restoration										Y	R		Y	R				
pulp therapy													Y	R				
extractions										Y	R		Y	R				
emergent services for pain/infection										Y	R		Y	R				
Medical Treatment	Y	NS		Y	R					Y	NS		Y	R		Y	NS	
Annual Health Assessment	PA			Y						NS			PA			Y		
Mental Health Consult. (if necessary)										Y	NS							
B. SUPPORTIVE SERVICES																		
Health Education	Y												Y			Y		
Records Maintained for Each Child	Y			Y						Y			Y			Y		
provision for parent's copy																Y		
Confidentiality	Y												Y					
Parent Consent													Y			Y		
Parent/Consumer Involvement																		
Staff Examination																		
Staff Training/Orientation	Y			Y														
Provision for Coordination & Linkage	Y			Y						Y								

CODES

1 - Written provision for services. 2 - Reimbursement. 3 - Limitations/Restrictions.

CF - part of comprehensive fee	NS - not specified
II - if indicated	PA - periodic assessment
N - no provision	R - reimbursable
NR - not reimbursable	Y - yes

*Procedures/rates for reimbursement not specified in plan.

TABLE X-A (Cont'd.)

HEAD START PERFORMANCE STANDARDS	TARGET STATES																	
	Ohio			Texas			Mo.			Mont.			Calif.			Ore.		
A. HEALTH SERVICES	1	2*	3	1	2*	3	1	2	3	1	2	3	1	2	3	1	2	3
History																		
medical	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
developmental	Y			Y									Y	CF		Y	CF	
Screening																		
growth assessment	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
vision testing	Y			Y			Y	CF		Y	CF		Y	R		Y	R	
hearing testing	Y			Y			Y	CF		Y	CF		Y	R		Y	R	
hemoglobin-hematocrit	II			Y			Y	CF		Y	CF		Y	R		Y	R	
tuberculin	II			Y			II	CF		Y	CF		Y	R		Y	R	
urinalysis	Y			Y			Y	CF		Y	CF		Y	R		Y	R	
assess immunizations	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
(if appropriate)																		
sickle cell	II			Y			Y	CF					II	R		Y	R	
lead poisoning	Y			Y			Y	CF					II	R		II	R	
intestinal parasites	II						N											
I.D. of speech problems	Y			Y						Y	CF					Y	R	
I.D. of needs of the handicapped													Y	NS				
Physical Examination	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
ear	Y			Y			Y	CF					Y	CF		Y	CF	
skin				Y									Y	CF				
eyes				Y						Y	CF		Y	CF		Y	CF	
nose	Y			Y			Y	CF					Y	CF		Y	CF	
throat	Y			Y			Y	CF					Y	CF		Y	CF	
heart	Y			Y			Y	CF					Y	CF		Y	CF	
groin													Y	CF				
Completion of Immunizations	Y			Y			Y	CF		Y	CF		Y	R		Y	R	
diptheria	Y			Y						Y	CF		Y	R		Y	R	
pertussis	Y									Y	CF		Y	R		Y	R	
tetanus	Y			Y						Y	CF		Y	R		Y	R	
polio	Y			Y						Y	CF		Y	R		Y	R	
measles	Y			Y						Y	CF		Y	R		Y	R	

SEE NEXT PAGE FOR CODES

TABLE X-A

HEAD START PERFORMANCE STANDARDS	TARGET STATES																	
	Ohio			Tex.			Mo.			Mont.			Calif.			Ore.		
	1	2*	3	1	2*	3	1	2	3	1	2	3	1	2	3	1	2	3
german measles	Y									Y	CF		Y	R		Y	R	
mumps	Y												Y	R		Y	R	
Nutritional Assessment	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
Nutritional Counseling/Education																		
Dental Screening:	Y			Y			Y	CF		Y	CF		Y	CF		Y	CF	
prophylaxis & oral hygiene education																Y	R	
fluoride application				Y						Y	CF					Y	R	
Dental Treatment				Y	R		Y	NS		Y	CF		Y	NS		Y	R	Y
restoration				Y												Y	R	
pulp therapy				Y												Y	R	
extractions				Y												Y	R	
emergent services for pain/infection							Y	NS										
Medical Treatment	Y			Y	R		Y	NS		Y	R		Y	R		Y	R	
Annual Health Assessment	PA			PA			Y			PA			PA			PA		
Mental Health Consult. (if necessary)				Y	NS					Y	CF		Y	NS		Y	R	Y
B. SUPPORTIVE SERVICES																		
Health Education	Y			Y									Y					
Records Maintained for Each Child	Y			Y			Y			Y			Y			Y		
provision for parent's copy				Y									Y			Y		
Confidentiality				Y						Y			Y					
Parent Consent	Y			Y						Y			Y					
Parent/Consumer Involvement													Y					
Staff Examination																		
Staff Training/Orientation	Y			Y			Y											
Provision for Coordination & Linkage	Y												Y					

CODES

1 - Written provision for services. 2 - Reimbursement. 3 - Limitations/Restrictions.

CF - part of comprehensive fee	NS - not specified
II - if indicated	PA - periodic assessment
N - no provision	R - reimbursable
NR - not reimbursable	Y - yes

*Procedures/rates for reimbursement not specified in plan.

TABLE X-A (Cont'd.)

HEAD START PERFORMANCE STANDARDS	TOTALS FOR TARGET STATES		
	1	2	3
A. HEALTH SERVICES			
History	2Y	2CF	
medical	9Y	7CF	
developmental	7Y	5CF	
Screening			
growth assessment	11Y	9CF	
vision testing	11Y	6CF; 2R; 1NR	1Y
hearing testing	11Y	5CF; 3R; 1NR	1Y
hemoglobin-hematocrit	9Y; 2II	4CF; 5R	
tuberculin	8Y; 3II	5CF; 3R; 1NR	
urinalysis	10Y; 1II	4CF; 5R	1Y
assess immunizations	11Y	9CF	
(if appropriate)			
sickle cell	7Y; 3II	3CF; 5R	
lead poisoning	6Y; 3II	2CF; 5R	
intestinal parasites	1Y; 3II; 1N	1CF; 1R	
I.D. of speech problems	5Y	2CF; 1R	
I.D. of needs of the handicapped	1Y	1NS	
Physical Examination	11Y	9CF	
ear	8Y	6CF	
skin	4Y	3CF	
eyes	7Y	6CF	
nose	8Y	6CF	
throat	8Y	6CF	
heart	7Y	5CF	
groin	3Y	3CF	
Completion of Immunizations	11Y	7CF; 2R	
diptheria	7Y	3CF; 2R	
pertussis	6Y	3CF; 2R	
tetanus	7Y	3CF; 2R	
polio	7Y	3CF; 2R	
measles	7Y	3CF; 2R	

SEE NEXT PAGE FOR CODES

TABLE X-A (Cont'd.)

HEAD START PERFORMANCE STANDARDS	TOTALS FOR TARGET STATES		
	1	2	3
german measles	6Y	3CF; 2R	
mumps	3Y; 2N	2R	
Nutritional Assessment	9Y	7CF	
Nutritional Counseling/Education	1Y	1NS	
Dental Screening:	11Y	6CF; 1NS; 2R	
prophylaxis & oral hygiene education	2Y	2R	
fluoride application	5Y	1CF; 1NS; 2R	
Dental Treatment	8Y	1CF; 3NS; 4R	
restoration	4Y	3R	
pulp therapy	3Y	3R	
extractions	4Y	3R	
emergent services for pain/infection	3Y	1NS; 2R	
Medical Treatment	11Y	4NS; 6R	
Annual Health Assessment	3Y, 1NS; 7PA		
Mental Health Consult. (if necessary)	5Y	1CF; 3NS; 1R	1Y
B. SUPPORTIVE SERVICES			
Health Education	6Y		
Records Maintained for Each Child	11Y		
provision for parent's copy	4Y		
Confidentiality	5Y		
Parent Consent	6Y		
Parent/Consumer Involvement	1Y		
Staff Examination	0		
Staff Training/Orientation	5Y		
Provision for Coordination & Linkage	5Y		

CODES

1 - Written provision for services. 2 - Reimbursement. 3 - Limitations/Restrictions.

CF - part of comprehensive fee
II - if indicated
N - no provision
NR - not reimbursable

NS - not specified
PA - periodic assessment
R - reimbursable
Y - yes

*Procedures/rates for reimbursement not specified in plan.

B. STATE MEDICAID PLAN PROFILE FOR TARGET STATES

The written EPSDT state plans did not, in many instances, encompass all aspects of the associated Medicaid plan and the provisions under which the state Title XIX agency actually operated specific EPSDT functions.

No state public welfare agency retained or totally delegated the management of all four functions under review. However, in Missouri and Oregon, the state welfare agency retained greater responsibility for three out of four functions, and only partially delegated the management of supportive services. On the other hand, the state public welfare agency in Illinois partially delegated all functions except fiscal, while the Massachusetts agency retained administration but partially delegated all others. California, however, totally delegated all functions except fiscal, which it partially delegated to another agency. In summary, the health function was most frequently "totally delegated"--eight out of 12 state public welfare agencies reviewed, or 67% overall--compared to the other functions. This pattern is to be expected since the management of the health function requires special expertise in health service delivery.

The function most frequently retained by the state public welfare agency, however, was fiscal management. Administration and support services were partially delegated to a greater extent than other functions. The diffusion of responsibility for managing various functions pertaining to EPSDT is not surprising given the history of the implementation of Title XIX among the states generally. There has been a marked tendency for health-related functions to be performed by public health rather than welfare agencies. However, many public welfare agencies have retained responsibility for fiscal management because of Title XIX requirements, but shared the operation of other administrative and support services. Because of the relatively low frequency with which the target state agencies retained the fiscal function, even though it was most often cited as being retained, it might be interesting to determine the extent to which this pattern correlates to the national trend.

This delegation of functions often underlies difficulties in coordination and poses problems to external entities, such as Head Start, which attempt to gain access to or influence the system.

SRS permitted the states to define eligibility for Medicaid in terms of either persons who are defined as categorically needy only (receiving financial assistance paid for in part by federal funds) or those who are categorically and medically needy (which may include persons with special needs for assistance regarding health services because of lower income or requirements for extensive health care). Analysis of the states' EPSDT plans indicated that six states--New Jersey, Mississippi, Ohio, Texas, Missouri, and Oregon--provided Medicaid, and therefore EPSDT services, only for those persons who were categorically needy. Massachusetts, Maryland, Tennessee, Illinois, Montana, and California, on the other hand, have more liberal eligibility criteria for Medicaid and include the medically needy. Information obtained in the on-site visits indicated that these differences had an important bearing.

It has been impossible, to date, to obtain complete information on the frequency with which states required redetermination of Medicaid eligibility. Redetermination is defined to mean personal interaction of the client with the responsible public agency, including presentation of supporting documentation required to continue Medicaid eligibility as opposed to internal review of status, etc., by the agency. According to available information, five states, (Maryland, Mississippi, Illinois, Texas, and Missouri) specify that eligibility determination is to be done at 6-month intervals. Since information is not available on the other seven states, no analysis of this dimension is provided in this report.

SRS regulations were explicit that the state EPSDT agency use as many different types of providers as possible in the implementation of the EPSDT program. SRS also encouraged efforts to provide vendor status for these various community providers and therefore reimbursement for services they render. The state plans were reviewed to determine the types of providers deemed eligible for vendor status under Medicaid. All of the target states deemed hospitals, private physicians/dentists, and other health practitioners to be eligible vendors. The provisions for eligibility of other health practitioners varied extensively, with categories such as chiropractors and optometrists being frequently included. California, did, however, include a number of the more recently recognized health practitioners within its definitions of eligible vendors. All states except Missouri included public health agencies, and Tennessee was the only state to include private voluntary clinics.

In general, most if not all, state EPSDT plans provided for traditional providers of medical and health services to be eligible vendors. There was a much lower frequency, only 50% of the states, of plans which allowed community agencies to achieve similar status. Such exclusion could potentially have an adverse effect upon the ability of the community EPSDT agency to mount an effective information, outreach and screening program. Conversely, this situation may impede Head Start efforts to obtain reimbursement for services it can provide more effectively. One alternative not explicitly identified by the table is joint vendor status, which is provided by Missouri. In this case, a community agency can be a vendor in concert with a more traditional provider. The Springfield project is scheduled to become a vendor under this provision, in concert with a local, and supportive, physician.

C. STATE/LOCAL EPSDT ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES

Because of the gaps in information and lack of specificity about organizational responsibility and operational reality detected in the sources mentioned previously, additional information was collected during the site visits in an attempt to amplify these materials. Information was solicited from selected Head Start projects, public agencies, and community agencies--including providers of service--regarding their knowledge of and experiences with the ongoing operation of EPSDT. Their comments and insights helped broaden the picture of the organizational and operational aspects of the EPSDT system; in general, however, their knowledge was limited to their experiences. In addition, materials pertaining to EPSDT that had been distributed by state or local agencies were collected and reviewed.

1. Analysis of Findings

In analyzing the type of relationships that existed at the state interagency level, we found that the relationship was defined through a contractual agreement in 14 instances. Only one state, Massachusetts, had an informal agreement at this level--in this instance between the public welfare and health agency. In New Jersey, the different state level agencies involved in EPSDT were structured so that they were ultimately responsible to the state public welfare agency, but functioned as semi-autonomous units.

In reviewing the 12 target states, we found the most frequently cited* parties to interagency relationships to be the public welfare and public health agencies (eight out of twelve states). The second most frequently cited interagency relationship involved the public welfare agency and a private insurance carrier. The frequency of welfare and health agency involvement is to be expected because of the requirements of Medicaid/EPSDT. It is of particular interest, however, that at least 50% of the target states--six out of twelve--contracted with a non-governmental entity, namely, a private insurance carrier such as Blue Cross, to be responsible for the fiscal management of EPSDT.

The public welfare agency was most frequently cited (ten out of 28 times) as having organizational responsibility for specific EPSDT functions. The next most frequently cited agency was the public health agency, eight out of twenty-eight times.

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*It is assumed that the public welfare agency is a party to the contract, even where it is not specifically cited, because of Title XIX requirements.

The medical function was most frequently found to be accomplished through an interagency agreement, thirteen times as compared to once for transportation. The states usually chose health-type units to be responsible for the medical function, e.g., public health department, state health agency, or a medical assistance unit. Since welfare agencies rarely have the resources to provide comprehensive health services, it is necessary for them to contract for the provision of such services.

In examining state and local governmental agency relationships, we found that ten out of twenty-two relationships involved the local welfare board. In seven states, however, the local board was a decentralized unit of the state public welfare agency. In such states, the local welfare board has considerable autonomy, and policies and procedures may vary from locality to locality with consequent confusion for agencies and individuals having to interact with them.

The fact that EPSDT was primarily maintained as a state administered program was reflected in the relationships between state and local agencies. In thirteen out of twenty-two such relationships cited, the relationship involved an organizational unit that was part of the state administrative system. In six instances, the unit was under local authority and the number of contracts needed and used to define the relationship between state and local units was drastically reduced.

Again, as in the case of state interagency relationships, the medical function was found to be most frequently delegated between state and local agencies--twelve out of twenty-two delegations of this nature existed. Health agencies were the primary factors at the level. A large degree of responsibility was also given to local units for follow-up and record-keeping, transportation, and notification of eligibles, including public information.

2. Conclusions on State/Local Organizational Responsibility In Target States

a. The responsibility for EPSDT is diffused over many agencies and levels of government. Although the limits of the various operational responsibilities (where one agency's responsibility ends and the other begins) were not specifically analyzed, it is apparent that the operational aspects of Medicaid/EPSDT are complicated. One agency certifies eligibles, another finds providers, and another services, sometimes from the state level and, in other cases, at the local level. Identifying which agencies are responsible for various aspects of the program is often difficult since there are few clear patterns across functions and activities.

b. Responsibility for support services seems to be vested in local governmental agencies. For instance, in seven states the local welfare board has responsibility for follow-up. The site visits indicated that in many areas, local welfare staff felt overextended with their regular caseloads and the additional responsibilities that EPSDT required made them feel even more overextended.

Ten states made provisions for transportation, primarily assigning it to local welfare boards. Information obtained in the site visits indicated that many EPSDT recipients have difficulty even in these states in securing EPSDT sponsored transportation, although theoretically they are entitled to this service. This example is only one of many illustrating the difficulties that occur when responsibilities are diffused among many units in different ways. Moreover, the paucity of formalized relationships tends to frustrate the efforts of community agencies such as Head Start to gain access to and recognition by this system.

3. Policy Considerations On State/Local Organizational Responsibility in Target States

- Information on the operational aspects of EPSDT should be provided to consumers and agencies (such as Head Start) interested in making effective use of these services.

D. PROVIDER PROVISIONS AND ATTITUDES BY SELECTED PROJECTS

An important issue for the implementation of the EPSDT program was the extent to which providers of EPSDT services, including Head Start agencies, could achieve vendor status.

1. Analysis of Findings

It was found that nine out of twelve of the target states placed restrictions on the vendor status of providers of Medicaid services. Only three states, Ohio, California, and Oregon, imposed no such restrictions, although all vendors cannot provide all types of services. As Table XIII indicates (see Appendix A), some states impose additional restrictions for EPSDT services.

Available information was also analyzed to determine whether there were limitations which specifically restricted the availability of providers/vendors to supply screening and treatment services for children eligible for EPSDT. There were proportionally fewer restrictions on providers/vendors treating EPSDT children. Only one state, Mississippi, reportedly imposes restrictions on treatment vendors, whereas four states--Mississippi, Tennessee, Illinois and Texas--place restrictions on vendors of screening services. In Maryland, there were no legal restrictions as to vendors screening EPSDT children. Many physicians have refused to complete the special set of EPSDT forms required by the state because they consider them a duplication of effort; thus they are not considered EPSDT providers. However, since Maryland made provision for preventive screening under its Medicaid plan, providers are performing screening services comparable to EPSDT, although these services are not recorded as such. In Illinois, where there were restrictions, physicians not only found the forms to be unacceptable but also disliked the bureaucratization of governmentally-funded medical services.

Three states required that providers complete an EPSDT participation agreement to screen or treat eligible children. In two of these states, Oregon and Illinois, this policy was applicable only to clinics. Two states had a preference for agreements--again for clinics--and two had no such regulation.

A number of states, however, provided for accountability measures regarding reimbursement procedures. Eleven of the twelve target states required separate billing on reporting forms for EPSDT. The rate system for reimbursement, however, allowed for much flexibility. For instance, only one state, Massachusetts, had a fixed fee for general Medicaid services, and four target states permitted physicians to charge their usual or customary fee.

The twenty-five selected projects were asked their perceptions about provider attitudes toward EPSDT rates and practices. In assessing the attitudes of public providers of EPSDT services, only twelve out of the twenty-five projects responded, because in other cases, public providers were not used by the projects or were not included under the state plan. Five of these 12 projects found public providers to be either positive or cooperative in their attitudes. Four projects indicated that there were no services available from the public sector.

There was a much higher response rate regarding the attitudes of private providers, with twenty-two out of twenty-five selected projects providing information in this area. Moreover, many projects described in detail their perceptions of providers from the private sector. In all, forty-two responses were recorded.

By and large, the projects percieved the private providers as negative in their attitude toward EPSDT. For instance, nine projects reported that the rates were unacceptable to the private sector and eight cited the forms as a source of contention.

Seven projects indicated that the private providers with whom they had contact refused or were reluctant to serve Medicaid patients. Only three projects found private providers to be positive or cooperative in their attitude. Of interest, though, is the fact that only one project felt that the private providers were uncooperative and four stated that the providers in their area were opposed to the state policy.

Comments from the selected projects reflected provider opposition to specific aspects of the EPSDT program (rates, forms, service definitions). The overall pattern was one of general resistance to EPSDT and to Medicaid. The role played by the state or local Medicaid/EPSDT agency in overcoming attitudinal barriers on the part of providers from the private sector is unclear. There is no question, however, that such barriers severely impact on the availability and accessibility of EPSDT services for children eligible for this program.

The selected projects in Maryland, Ohio and Texas were uniformly less critical of the attitudes of public and private providers of EPSDT services. Further analysis is needed to determine whether the pattern of EPSDT service delivery in these three states was more effective than that in the other target states.

E. SELECTED PROJECTS' RELATIONS WITH STATE AND LOCAL MEDICAID/ EPSDT AGENCIES

The guidelines for the Head Start/EPSDT Collaborative Effort explicitly called for Head Start to establish relationships with state and local Medicaid/EPSDT agencies in order to implement the demonstration effort.

1. Analysis of Findings

There was wide variation in the degree to which selected projects had initiated relationships with a state as opposed to a local Medicaid/EPSDT agency.

The findings indicated that the Head Start program was usually responsible for initiating the relationship with the Medicaid/ EPSDT agency. In about half (59%) of the selected projects, the relationships established with the local Medicaid/EPSDT agency had been initiated by the Head Start project alone. However, the health liaison specialist or the local Medicaid/EPSDT agency did share the responsibility with the project for initiating the relationship in other cases.

There were several factors which may have contributed to the marked difference in the nature and approach to relationships that Head Start projects developed with the state as compared to the local Medicaid/EPSDT agency. First of all, if the Head Start project perceived that maximum utilization of Medicaid resources was a means of increasing the range of services available, the project may have pursued this objective by initiating contact with the most readily accessible Medicaid/ EPSDT agency. The project would be most likely to contact a local unit rather than searching for the unit through which policy changes could be negotiated. Moreover, many state agencies which were responsible for the Medicaid/EPSDT program either had decentralized program operations or had delegated part of all of the program functions to another agency at the local level.

In either event, however, the responsibility for making policy and setting Medicaid/EPSDT standards was usually retained at the centralized level. Therefore, the type of agreement to be established between the local Medicaid/EPSDT agency and the Head Start program regarding the delivery of services could be, at best, only informal with little impact upon the institutional arrangements for the delivery of Medicaid/EPSDT services. In order for institutional changes to occur, there would have had to be involvement or approval of the state unit with ultimate responsibility for the Medicaid/EPSDT program.

2. Conclusions on Relationship with State/Local Medicaid/ EPSDT Agencies

a. The data indicate that there was an overall inability on the part of the Head Start program to be fully integrated into the delivery system of Medicaid/EPSDT services at the state or local level. No project reported that it was able to be reimbursed for either a limited or full range of the EPSDT related services it may have provided, and only the project in Eugene, Ore., achieved vendor status under the state Medicaid/EPSDT program

b. The Head Start/EPSDT Collaborative Effort had minimal, if any, impact upon the institutional arrangements of state Medicaid/EPSDT programs. It is highly unlikely that an individual Head Start project would have the power or influence to effect institutional change in the bureaucratic organization of state Medicaid/ EPSDT services without external support from higher levels of government.

3. Policy Consideration on Relationship with State/Local Medicaid Agencies

- Major responsibility for establishing Head Start as an integral part of the delivery system for Medicaid/EPSDT services, therefore, would appear to reside at the federal level. SRS, for instance, could review the utilization of Head Start in providing certain specific services rendered where appropriate. Moreover, as a demonstration effort, OCD regional personnel, particularly the health liaison specialists, could be more actively involved in initiating and following through on contacts to insure that formalized relationships between the Head Start project and the appropriate state or local Medicaid/EPSDT agency are established and maintained.

VIII. TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR SELECTED PROJECTS

In assessing the adequacy of technical assistance received from various sources, 56% (14 out of 25) of the selected projects found that help given by the health liaison specialist was more useful than that available from state or local Medicaid/ EPSDT agencies. Five of the projects also indicated that the technical assistance from the public agencies was equally sufficient.

The state Medicaid/EPSDT agency was more frequently cited than other agencies as not having provided any technical assistance, and one project, Toms River, N. J., stated that it had not received assistance from any source.

The selected projects were also asked about the specific type of technical assistance they had received and the source. The type of technical assistance assumed to be available ranged from meeting information and communication needs to improving program and administrative functioning. Moreover, it was expected that the health liaison specialist would be primarily involved in serving informational/communicative functions and the state or local agency would be primarily responsible for assisting in those areas which required specific program expertise.

1. Analysis of Findings

The most frequent type of technical assistance provided was in the form of workshops and information provision; fourteen projects reported that they had received technical assistance in improving their relationship with the EPSDT agency. It should be noted that in one project--El Centro, California--SRS was the source of assistance. At the other extreme, no project had received any assistance in improving its fiscal arrangements and only six had received any help in improving their supportive services.

The health liaison specialist was most frequently cited as the source of technical assistance. The major type of technical assistance provided by the health liaison specialist was through workshops and information provision. The health liaison specialists were relatively active in improving relationships with the EPSDT agency.

The minimal amount of technical assistance provided by various sources beyond workshops and information strongly suggests the reason why Head Start programs failed to change institutional arrangements in their relationship with EPSDT agencies.

A substantial proportion (14) of the selected projects found the health liaison specialist to be sufficient in providing technical assistance. Yet, the major type of assistance provided by the specialist was at the informational level. This attitude may have reflected a hesitancy to criticize the specialist. It may also be attributable to the fact that either the Head Start programs had very little understanding of the objectives of the collaborative effort, particularly regarding their roles; or there was a lack of awareness about the technical assistance that could be obtained from the health liaison specialist or other sources.

Of equal significance was the minimal role played by the state and local Medicaid/EPSDT in providing technical assistance. Most state plans specifically called for technical assistance activity by the EPSDT agency ranging from improving outreach and supportive services to enhancing the capacity of providers to deliver hard services. It is conceivable that the state and local EPSDT agencies did not appreciate the role to be played by Head Start programs in the Medicaid/EPSDT program and therefore exercised little initiative in offering technical assistance.

As part of the evaluative study, the evaluation staff sought to identify the technical assistance needs of the selected projects during the on-site visits. This aspect of the site visits was not specifically addressed as such with the projects, and the assessments represent the judgment of the staff as to the overall operation of the collaborative effort and the information needs of the projects as viewed by responses to specific questions, familiarity with the EPSDT objectives, and observations of the various procedures set up to implement the effort.

Twenty out of 25 projects were found to need workshops and information. Of these 20 projects, 19 stated that they had received this type of technical assistance, which suggests that there was need for additional help. Of even greater significance was the fact that 11 of the 20 stated that the workshop and information had been provided by the health liaison specialist. Further, they had found the specialist to be sufficient. One may conclude, therefore, that the projects had low expectations for the conduct of the workshops and provision of information.

The evaluation staff also found that a large majority, 21 out of 25 selected projects, needed technical assistance in improving their planning and administration, and an even greater number needed help in improving their supportive services.

2. Conclusions on Types and Adequacy of Technical Assistance

a. Head Start projects indicated that the technical assistance which they received for implementing the EPSDT effort tended to be less than adequate. To the degree that any source was helpful, the health liaison specialist was more frequently cited. State Medicaid/EPSDT agencies, on the other hand, were usually no source of technical assistance at all.

b. The most frequent type of technical assistance provided was in the form of workshop and information provision. No project, however, received assistance in making fiscal arrangements and few indicated that they had been assisted in implementing other administrative procedures.

3. Policy Considerations on Types and Adequacy of Technical Assistance

a. OCD might initiate a specific program of training and technical assistance to enable all Head Start programs to carry out the EPSDT Collaborative Effort more effectively. Administration and planning, as well as the development of coordinative linkages with state EPSDT agencies, would be areas of concentration.

b. The role of the health liaison specialist might be more clearly defined in regard to its ongoing technical assistance function and as a liaison between the Head Start projects and the state EPSDT agencies.

IX. COST/REVENUE IMPACT OF THE HEAD START/EPSDT COLLABORATIVE EFFORT

Introduction

A major task for the evaluation of the Head Start/EPSDT Collaborative Effort was to assess the cost impact of the program on the participating demonstration projects. Attention was also to be given to the quantifiable outcomes of the collaboration regarding reimbursement revenues and the particular revenue sources obtained by the various projects to support the effort, as well as the assessed value of services received by the participating groups (selected projects only). The following tables, therefore, analyze information germane to the cost/revenue aspects of the demonstration program:

- Table XVII - Revenue Sources Used to Support the Head Start/EPSDT Collaborative Effort
- Table XVIII - Head Start/EPSDT Expenditures by Source
- Table XIX - Head Start/EPSDT Expenditures Re: Direct, Supportive and Administrative Costs; Cost Per Child
- Table XX - Medicaid Involvement in the Payment of EPSDT Services for Medicaid Certified Participants.

The instruments used to collect data presented in the above tables were the Head Start/EPSDT Income Sources Form, the Head Start EPSDT Expenditure Form, and the Health Care Encounter Form.

The response rate of the demonstration projects to the aforementioned instruments was relatively low. As of this report, a total of 46 (23%) of the 198 participating projects submitted the Income Sources Form. Eight of these projects were selected projects. Even fewer projects responded to the Expenditure Form. Only 45 projects (21%) of all the projects forwarded information via this instrument. Of these projects, five were selected projects.

Repeated efforts were made during the course of the evaluation to obtain the requisite information. In each instance, those projects not responding were contacted and requested/encouraged to complete and return the forms as soon as possible. The projects were advised of the importance of their response relative to the validity of the evaluation study. These efforts, however, had no material impact on the response rate. It should be noted that completion of these forms came at the end of the year. It was, therefore not possible to persist in seeking this information since many projects were closed, and staff was not available.

The primary reason for the low response rate may have been the lack of cooperation the health coordinators received from the fiscal officer* of the program. Without assistance from this staff person, many health coordinators felt at a loss to attempt completion of the forms themselves. Moreover, many projects did not understand the information being requested and failed to inquire. Nonetheless, because of the low response rate to both forms, any definitive statements made regarding the data tables are only relative to the universe of projects reporting. Speculation as to the revenue/cost impact of the collaborative effort can only be advanced concerning the balance of projects not reporting.

It should further be noted that the information reported by these projects was not subject to audit and, therefore, was taken at face value.

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*This individual was designated responsibility to assist the health coordinator in completing the Income Sources Form and the Expenditure Form.

A. REVENUE SOURCES OBTAINED BY THE DEMONSTRATION PROJECTS TO SUPPORT THE COLLABORATIVE EFFORT

A profile of revenue sources obtained by the various demonstration projects to support the Head Start/EPSDT Effort is provided in Table XVII. Information was taken from the Income Sources Form and arrayed by region, state, and program to indicate the extent to which each region, state and program made maximum use of all available resources regarding the implementation of Head Start/EPSDT.

This table outlines six possible sources of revenue that may have been used by the demonstration projects in support of the collaborative effort. These are:

- Governmental - amount of monies received/earned through federal, state and local grants in connection with the Head Start/EPSDT Collatorative Effort.
- Third Party Payors - amount of monies received/earned through third-party payors such as Medicaid (Title XIX) and other purchase of service agreements that have been reached.
- Direct Patient Payments - amount of dollars received/earned through direct payments made by families on behalf of children participating in the collaborative effort.

- Cash Contribution - amount of unearned income from voluntary contributions, e.g., foundations, endowments, etc.
- Donated Services and Materials - the assessed value of in-kind support from non-cash donations, e.g., volunteer personnel services, materials and other contributions of a non-cash nature which are incremental to program services
- Other Revenue - amount of any other revenue from income--earning efforts such as sales, interest, etc.--not previously listed.

As a point of reference, none of the 198 demonstration projects participating in the Head Start/EPSDT Collaborative Evaluation (with the exception of Eugene, Oregon) had reached agreements with state/local Medicaid agencies for direct third-party reimbursement. This, however, was not a priority objective of the first year effort. It is anticipated that the second year evaluation will place more emphasis on the demonstration projects securing direct third party monies through purchase of service agreements with state/local agencies. Thus, monies shown in Table XVII as Title XIX/Medicaid did not constitute vendor status* on behalf of the project. Rather, data from this table represented the projects' estimate of Title XIX monies obtained by health providers for services rendered to Medicaid eligible children (of the respective projects) participating in the collaborative effort.

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*Vendor status - recognized as a provider of health services (for which Title XIX monies can be received) by the state/local Medicaid agency.

1. Analysis of Findings

Table XVII shows that an overwhelming majority of the demonstration projects reporting were very much dependent upon the supplemental grant provided by the federal government for support of the Head Start/EPSDT effort. Project grants ranged from $500 to $16,500 as reported by Jackson County Child Development Centers of Medford, Oregon and Prairie Opportunity, Inc. of Starkville, Mississippi respectively. Monies generated through other sources were minimal by comparison and in some categories no monies were reported at all.

It appears that there was no direct relationship between the number of children enrolled and/or participating in the Head Start/ EPSDT Collaboration, by project, and the amount of monies allocated by project, for the implementation of the collaborative effort. For example, the South Middlesex Opportunity Council of Farmingham, Massachusetts indicated it planned to serve 250 children for which it received $10,000 in supplemental monies. In contrast, the Paterson Task Force for Community Action of Paterson, New Jersey only received $8,000 from the federal government with a planned population of over 5,000 to be served. Thus the rationale for the distribution of supplemental funds was not clearly discernible.

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Payment	Found-ations	Endowments	Private	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION I													
Massachusetts:													
Framingham	$10,000			$ 9,500						$12,000	$ 1,000		$32,000
*Gloucester	10,000												10,000
Turner Falls	10,200		$ 400	16,974	$ 1,561					925	15	$ 62	30,137
*Pittsfield	10,000												10,000
Danielson	10,000										110	16	10,126
Total	$50,200		$ 400	$26,474	$ 1,561					$12,925	$ 1,125	$ 78	$92,763
Vermont:													
Newport	$10,000			$ 114						$ 585			$10,699
*Winooski	10,000												10,000
Total	$20,000			$ 114						$ 585			$20,699
Connecticut:													
Jewett City	$10,000									$ 4,000			$14,000
Regional Totals	$80,200		$ 400	$26,588	$ 1,561					$17,510	$ 1,125	$ 78	$127,462
REGION II													
New York:													
Watertown	$ 8,000									$ 1,237			$ 9,237

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION II (CON'T)													
New Jersey:													
*Orange	8,000												8,000
Toms River	20,005	$ 2,906	$ 1,487		$ 2,000								26,398
Paterson	8,000											$ 2,296	10,296
Total	$36,005	$ 2,906	$ 1,487		$ 2,000					$ 1,237		$ 2,296	$44,694
Regional Totals	$44,005	$ 2,906	$ 1,487		$ 2,000					$ 1,237		$ 2,296	$53,931
REGION III													
Maryland:													
Salisburg				$ 550						$ 200	$ 25		$ 775
Regional Totals				$ 550						$ 200	$ 25		$ 775
REGION IV													
Mississippi:													
Starkeville	$16,500			$3,800						$2,200		$ 250	$22,750
Yazoo	5,649			191	$3,380								9,220
Total	$22,149			$3,991	$3,380					$2,200		$ 250	$31,970

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION IV (CON'T)													
Tennessee:													
Kingston	$10,000			$ 1,949	$ 150	$ 530				$ 280			$12,909
Alabama:													
* Anniston	$10,000												$10,000
Georgia:													
Monticello	$10,000								$ 25				$10,025
Gainesville	10,000									1,750	50	200	12,000
Total	$20,000								$ 25	$ 1,750	$ 50	$ 200	$22,025
Kentucky:													
Frankfort	$16,000									$ 4,000			$20,000
Regional Totals	$78,149			$ 5,940	$ 3,530	$ 530			$ 25	$ 8,230	$ 50	$ 450	$96,904
REGION V.													
Illinois													
Cook County	$15,000									$ 200	$ 300		$15,500
Waukegan	10,000									6,000	100	2,811	18,911
Total	$25,000									$ 6,200	$ 400	$2,811	$34,411

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Foundations	Endowments	Private Contributions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION V (CON'T)													
Wisconsin													
• Wisconsin Rapids	$ 5,000												$ 5,000
• Superior	10,000												10,000
Total	$15,000												$15,000
Regional Totals	$40,000									$ 6,200	$ 400	$ 2,811	$49,411
REGION VI.													
Texas:													
Wichita Falls	$ 5,000			$ 3,494	$ 404					$ 98			$ 8,996
• San Antonio	5,000												$ 5,000
Amarillo	10,000										50		10,050
Total	$20,000			$ 3,494	$ 404					$ 98	$ 50		$24,046
Arkansas:													
• Hot Springs	$ 5,000												$ 5,000
Oklahoma:													
Chickasha	$ 5,000									$ 1,000	$ 200	$ 1,900	$ 8,100
Regional Totals	$30,000			$ 3,494	$ 404					$ 1,098	$ 250	$ 1,900	$37,146

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION VII.													
Missouri:													
Joplin	$ 5,000									$ 1,100	$ 35	$ 40	$ 6,175
Kirkville	5,000			525									5,525
Total	$10,000			$ 525						$ 1,100	$ 35	$ 40	$11,700
Kansas:													
Horton	$ 5,000												$ 5,000
Girard	5,000			4,502							75	750	$10,327
Total	$10,000			$ 4,502							$ 75	$ 750	$15,327
Regional Totals	$20,000			$ 5,027						$ 1,100	$ 110	$ 790	$27,027
REGION VIII.													
Colorado:													
Pueblo	$ 3,900				$10,000							$ 250	$14,150
Trinidad	5,000			642							481		6,123
Total	$ 8,900			$ 642	$10,000						$ 481	$ 250	$20,273
Utah:													
Salt Lake City	$50,920									$ 8,000	$ 100		$59,020
Regional Totals	$59,820			$ 642	$10,000					$ 8,000	$ 581	$ 250	$79,293

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION IX.													
Hawaii:													
Kauai	$ 8,979	$ 3,980											$12,959
Regional Totals	$ 8,979	$ 3,980											$12,959
REGION X.													
Oregon													
Scappoose	$13,331			$ 1,612						150	25	243	$15,361
La Grande	14,586									221			14,807
Medford	500			13,000 Est.						$ 2,840	10	500	16,850
Salem	5,700												5,700
Roseburg	12,130			1,892							5,148		19,170
Total	$46,247			$16,504						$ 3,211	$ 5,183	$ 743	$71,888
Regional Totals	$46,247			$16,504						$ 3,211	$ 5,183	$ 743	$71,888

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Pegion/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
IMPD PROGRAMS													
Montana:													
Blackfeet	$ 3,400												$ 3,400
Flathead	8,498			840	1,230					584			11,152
Fort Peck	6,600			2,340									8,940
Total	$ 18,498			$ 3,180	$1,230					$ 584			$ 23,492
Nesbraska:													
Santee Sioux IMPD Totals	$ 5,900												$ 5,900
Regional Totals	$ 24,398			$ 3,180	$ 1,230					$ 584			$ 29,392
SUMMARY TOTALS	$ 431,798	$ 6,886	$ 1,867	$61,925	$18,725	$ 530	-0-	-0-	$ 25	$47,370	$ 7,724	$ 9,318	$586,188

A total of $586,188 was obtained/generated for the collaborative effort among the 46 projects reporting. Exhibit V illustrates the percentage distribution of this amount between the respective revenue categories. The distribution shows that federal funds (supplemental grant) of $431,798 far out-distanced the other categories as the major contributor to the Head Start/EPSDT effort and accounted for 73.7% of all monies generated. In addition, monies generated through Medicaid/Title XIX ($61,925/10.6% of total) and Donated Services and materials ($55,094/9.4% of total) combined to represent 20% of the total funds available to support the collaborative effort. These categories, together, became the second largest supporter of the collaboration. Exhibit V also indicates that very few dollars were provided through state and local governments, cash contributions, etc.

The data supports, as previously indicated, a strong reliability on the supplemental grant for maintenance of the demonstration program. Table XVII shows that eleven (24%) of the 46 projects reporting rely solely on supplemental grant dollars for support. These programs are identified in the table by an asterisk (*) placed next to their names. Analysis also reveals a modest dependence on Donated Services and Materials. It is interesting to note that five projects indicated financial support in this area ranging from 20% to 36% of the total of all monies received. Reference Exhibit VI.

EXHIBIT V

PERCENTAGE ALLOCATION OF MONIES RECEIVED IN SUPPORT OF COLLABORATIVE EFFORT

CATEGORY	AMOUNT	%
Federal Government	$ 431,798	73.7
State Government	6,886	1.2
Local Government	1,887	.3
Medicaid (Title XIX)	61,925	10.6
* Other	18,725	3.2
Direct Patient Payments	530	.1
Cash Contributions:		
Foundations	-0-	-
Endowments	-0-	-
Private	25	-
Donated Services and Materials:		
Services	43,370	8.1
Materials	7,724	1.3
** Other	9,318	1.5
Totals	$ 586,188	100.0%

* Other monies obtained through third party sources.

** Other income earning efforts in support of the collaborative effort such as sales, interest, etc. not previously recorded.

EXHIBIT VI

COMPARISON OF FINANCIAL SUPPORT

Head Start/EPSDT Project	Total All Monies Received In Support of Effort	Total Monies Received-Donated Services & Materials	Percentage Relationship
South Middlesex Opportunity Council Framingham, Massachusetts	32,500	12,000	36%
Thames Valley Council Jewitt City, Connecticut	14,000	4,000	28%
Kentucky Youth Research Frankfort, Kentucky	20,000	4,000	20%
Lake County C.A.P. Waukegan, Illinois	18,911	6,000	31%
Parent Action Council Roseburg, Oregon	19,170	5,148	26%

Most other projects, as Table XVII shows, reported revenues from Donated Services and Materials. These amounts, however, were not significantly large and would not greatly impact on support of the collaborative effort.

What is obvious from the data is that few projects had financial commitments from sources other than the federal, state, and local governments. Contributions from the private sector (foundations, endowments, individuals, etc.) were simply non-existent. This, however, is not surprising as most programs were not engaged in a community-wide effort to solicit money from private sources to support the Head Start/EPSDT program. This was also not a priority objective of the program.

Region I reported receiving $127,462 in support of the collaborative effort. This was the highest amount reported among the regions and IMPD programs. The best return rate of the Revenue Sources Form was also experienced in this region with 50% (10 out of 20) of the programs submitting the requisite information. This, of course, contributes significantly toward the amount indicated and suggests that other regions may have fared as well or better depending upon their response rates. Region III, on the other hand, reported obtaining $775--the least among the regions and IMPD programs. The response rate in this region was very poor with only one of the ten affiliate projects reporting. Again, the poor response rate is directly attributable to the minimal amount reported. The variations in responses among the regions, therefore, preclude making objective comparisons regarding the amount of monies received.

2. Conclusions on Revenue Sources Obtained to Support the Collaborative Effort

a. Supplemental grants received by the demonstration projects varied widely. There was no apparent correlation between project size (number of children to be served) and the amount of monies allocated per project for implementation of the collaborative effort.

b. To a very large extent, most of the demonstration projects depend upon the supplemental grant for support of the effort. For every dollar generated in support of the effort, the supplemental grant represented approximatley 74 cents. It is further concluded that the collaborative effort could suffer greatly, if the supplemental grants were discontinued as most programs show no immediate alternative method of financing.

c. Despite the reliance by the demonstration projects on the supplemental grant, some projects showed initiative in generating dollars through Medicaid/Title XIX and Donated Services and Materials. These categories accounted for 20 cents of every dollar spent by the projects on the Head Start/EPSDT Collaborative Effort.

d. Monies generated outside the government agencies were of very little consequence.

e. It can be speculated that if information were available on the balance of projects not reporting, it would have little influence on the above conclusions reached, particularly regarding the distribution of the supplemental grant monies and dependence on same for support of the collaborative effort.

3. Policy Considerations on Revenue Sources Obtained to Support The Collaborative Effort

a. If the supplemental grant is to continue, it is suggested that monies could be distributed based on a formula that reflects program size and other variables. This could greatly contribute to an equitable means of allocating supplemental monies among the programs.

b. Programs could be encouraged to begin soliciting sources other than the supplemental grant for support of the collaborative effort. Suggestions are:

- recognition as a provider of health services by the local/state Medicaid agency, whereby third party monies accrue directly to the demonstration project. These monies can then be reprogrammed or earmarked for subsequent EPSDT health and support related services.

- where provider recognition is not possible, programs may be encouraged to reach agreements with local health providers (which are recipients of third party revenues) to share in any monies they receive as a result of services rendered to children of the local projects. As in the above situation, these monies can be used for future EPSDT services

- implementation of direct patient payments (for non-Medicaid eligible families only) predicated on a sliding fee scale system which takes into account the family's ability to pay

- solicitation at the local community level to attract monies from the private sector, e.g., sponsorships, contributions, loans, etc.

B. SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT (TABLES XVIII AND XIX)

The expenditure form was used to collect information on the amount of monies expended by the demonstration projects in support of the collaboration effort. The form was also designed to assess the per child cost of screening and treatment and related supportive and administrative services. Information reported was for the period July 1, 1974, to June 30, 1975.

There was wide disparity in reporting among the demonstration projects regarding the expenditure form as compared to its counterpart--the income form. It appears that most projects did not understand that the amount of monies reported as available for the collaborative effort (reference Table XVII) was directly related to the amount of monies that could be expended on the effort. In fact, many projects reported more monies expended than were actually available.

Because of the lack of data and, in some instances, its unreliability, it was not possible to undertake the kind of analysis anticipated. Therefore, no conclusions can be drawn relative to the cost impact of the Head Start/EPSDT Collaborative Effort for the universe of 198 projects. However, for those projects reporting, the available data on the dispersion of these costs are summarized in Tables XVIII and XIX. Conclusions and recommendations as to the findings also follow, but are limited to the universe of projects reporting.

Information by region, state and project concerning the source of expenditure for the collaborative effort, e.g., Head Start/ EPSDT (supplemental grant), cash contributions, in-kind contribution, etc., is presented in Table XVIII. The table further summarizes the total amount of expenditure from all sources for each region, state and project.

Monies expended by the demonstration projects on the collaborative effort (including EPSDT payments to providers, as estimated by the projects) are categorized into three major groupings in Table XIX:

- Direct Costs
- Supportive Cost
- Administrative Costs

This table further provides the per child cost of EPSDT services, by dividing the universe of children served into the total cost of all services rendered.

Definition of Terms

Direct Costs refers to those costs which are directly attributable to services rendered to children and their families participating in the Head Start/EPSDT program, e.g., wages paid to staff personnel directly involved in administering medical services, cost of supplies (prostheties, pharmaceuticals, etc.) used in the course of rendering health services, etc.

Supportive Costs refers to those costs which are necessary to ensure quality and ongoing services to children and their families, e.g., wages paid to staff persons who are not directly involved in EPSDT medical treatment, but who perform functions which induce better or continuing patient services, such as outreach, EPSDT staff training, etc. The cost of providing transportation to and from the clinic setting would also be germane to this category.

Administrative Costs refers to those costs which support overall Head Start/EPSDT operations, but which are not associated with direct medical services to the collaboration participants, e.g., wages paid to Head Start/EPSDT administrative staff, cost of transportation, materials, etc., which are attribritable to EPSDT administrative functions.

1. Analysis of Findings (Table XVIII)

Projects reported that they spent a total of $656,383 on the collaborative effort. As expected, the majority of these monies, $496,087 (76%), came from the Head Start/EPSDT supplemental grant. Other federal dollars in the amount of $68,591* paid for 10% of health and related EPSDT services provided to children, thus representing the second largest expenditure source in support of the collaboration. Contributions from other sources were significantly less. Exhibit VII provides data on the amount of contribution by expenditure source and its distribution as a percentage of the total.

Interestingly, EPSDT Medicaid was rarely a source of funds used regarding health services to all Head Start/EPSDT participants. Figures show that only 6%, $41,858, was used for health and related services from this source. This may have been a result of under-reporting by the projects. However, Medicaid's participation as a funding source increases relative to Medicaid payments for services rendered to Medicaid certified children--both Head Start and non-Head Start. This will be explained in next section. For example, projects reported

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*This amount appears unusually high and may be the result of misinterpretation. That is, some programs may have inadvertently reported expenditures from the supplemental grant under the "Federal" category as opposed to the "Head Start/EPSDT" expenditure category.

EXHIBIT VII

SOURCE OF EXPENDITURES FOR HEAD START/ EPSDT COLLABORATIVE EFFORT

Expenditure Source	Amount	Contribution By Source
Head Start/EPSDT	$496,087	76%
Non-Cash In-Kind Contributions	32,062	5%
Cash Contributions	69	-
Federal (Other than Supplemental Grant	68,591	10%
State	5,743	1%
Local	4,529	1%
EPSDT/Medicaid	41,858	6%
Other	7,445	1%
TOTAL	$656,384	100%

NOTE: Information is based on a total of 45 projects reporting, which represents 23% of the 198 projects participating in the Collaborative Effort.

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII

Projects by Region/State	Head Start/ EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION I									
Massachusetts: Gloucester	$ 11,325								$ 11,325
Pittsfield	19,322		$ 40						19,362
Greenfield	2,046	$ 319				$ 190	$ 1,131	$ 60	$ 3,746
Total	$ 32,693	$ 319	$ 40			$ 190	$ 1,131	$ 60	$ 34,433
Vermont: Newport	$ 10,150								$ 10,150
Winooski	10,000								10,000
Total	$ 20,150								$ 20,150
Connecticut: Danielson	$ 9,684	$ 141		$ 13,661			$ 2,146		$ 25,632
Jewett City	9,886	$ 4,000							$ 13,886
Total	$ 19,570	4,141		$ 13,661		$ 190	$ 2,146		$ 39,518
Regional Totals	$ 72,413	$ 4,460	$ 40	$ 13,661		$ 190	$ 3,277	$ 60	$ 94,101
REGION II									
New York: Watertown	$ 8,102	$ 1,135							$ 9,237

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION II (CONT)									
New Jersey: Orange	$ 5,278								$ 5,278
Regional Totals	$13,380	$ 1,135							$14,515
REGION III									
Maryland: Salisburg	$10,000	$ 225					$ 550		$10,775
West Virginia: Roanoke	$ 5,567								$ 5,567
Regional Totals	$15,567	$ 225					$ 550		$16,342
REGION IV									
Mississippi: Starkeville	$ 8,240						$ 3,800		$12,040
Yazoo	12,300			$ 5,649	$ 3,380		191		21,520
Total	$20,540			$ 5,649	$ 3,380		$ 3,991		$33,560
Tennessee: Kingston	$ 6,866	$ 24	$ 4		$ 334	$ 120	$ 715		$ 8,063
Alabama Anniston	$ 7,976								$ 7,976

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION IV (CONT.)									
Georgia:									
Monticello	$ 10,252	$ 489	$ 25	$ 1,513		$ 640	$ 320		$ 13,239
Gainesville	13,000	300							13,300
Total	$ 23,252	$ 789	$ 25	$ 1,513		$ 640	$ 320		$ 26,539
Kentucky:									
Frankfort	$ 16,000	$ 4,000							$ 20,000
Regional Totals	$ 74,634	$ 4,813	$ 29	$ 7,162	$ 3,714	$ 760	$ 5,026		$ 96,138
REGION V									
Illinois:									
Cook County	$ 30,016	$ 3,173		$ 3,254		$2,746	$22,230		$ 61,419
Waukegan	15,035	6,100						$ 2,811	23,946
Total	$ 45,051	$ 9,273		$ 3,254		$2,746	$22,230	$ 2,811	$ 85,365
Wisconsin:									
Wisconsin Rpds.	$ 5,000								$ 5,000
Superior	5,503								5,503
Total	$ 10,503								$ 10,503
Regional Totals	$ 55,554	$ 9,273		$ 3,254		$2,746	$22.230	$ 2,811	$ 95,868

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION VI									
Texas:									
Witchita Falls	$ 3,951	$ 98				$ 404	$ 3,494		$ 7,947
San Antonio	5,904								5,904
Amarillo	5,000	900		$ 2,653	$ 1,000				9,553
Total	$ 14,855	$ 998		$ 2,653	$ 1,000	$ 404	$ 3,494		$ 23,404
Arkansas: Hot Springs	$ 21,909	$ 3,070							$ 24,979
Louisiana: Alexandria	$ 9,387			$ 5,000					$ 14,387
New Mexico: Carlsbad	$ 6,509	$ 1,995							$ 8,504
Oklahoma: Chickasha	$ 37,242								$ 37,242
Regional Totals	$ 89,902	$ 6,063		$ 7,653	$ 1,000	$ 404	$ 3,494		$108,516
REGION VII									
Missouri: Joplin	$ 6,175								$ 6,175
Kirkville	5,102						$ 525		5,627

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION VII (CONT.)									
Appleton City	$ 5,000								$ 5,000
Total	$ 16,277						$ 525		$ 16,802
Kansas:									
Horton	$ 5,148								$ 5,148
Girard	42,894	$ 825					$4,502		$ 48,221
Total	$ 48,042	$ 825					$4,502		$ 53,369
Regional Totals	$ 64,319	$ 825					$5,027		$ 70,171
REGION VIII									
Colorado:									
La Junta	$ 4,950	$ 852		$ 4,400		$ 429			$ 10,631
Pueblo	4,825	30		10,000					14,855
Trinidad	5,000	618		3,422			$ 642	$ 1,920	11,602
Total	$ 14,775	$ 1,500		$ 17,822		$ 429	$ 642	$ 1,920	$ 37,088
Regional Totals	$ 14,775	$ 1,500		$ 17,822		$ 429	$ 642	$ 1,920	$ 37,088
REGION IX									
Hawaii:									
Kauai	$ 6,826			$ 9,140	$ 1,029				$ 16,995
Regional Totals	$ 6,826			$ 9,140	$ 1,029				$ 16,995

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION X									
Oregon:									
La Grande	$ 11,939								$ 11,939
Eugene	43,280	$ 3,350							46,630
Salem	5,700			$ 9,899					15,599
Clatskanie	13,331	418					$ 1,612		15,361
Total	$ 74,250	$ 3,768		$ 9,899			$ 1,612		$ 89,529
Regional Totals	$ 74,250	$ 3,768		$ 9,899			$ 1,612		$ 89,529
IMPD PROGRAMS									
Minnesota:									
White Earth	$ 45								$ 45
Montana:									
Flathead	$ 8,498							$ 2,654	$ 11,152
Nebraska:									
Santee Sioux	$ 5,924								$ 5,924
IMPD Totals	$ 14,467							$ 2,654	$ 17,121
SUMMARY TOTALS	$496,087	$32,062	$ 69	$68,591	$ 5,743	$ 4,529	$41,858	$ 7,445	$656,384

$61,925 in Title XIX monies available for the collaborative effort through revenue sources. It, therefore, seems reasonable that this amount would have been expended. On the other hand, a substantial portion of the various screening tests, usually performed by the health providers, may have been administered by the Head Start/EPSDT staff itself. This would have, of course, precluded Medicaid/EPSDT reimbursements and contributed to a lower percentage of Medicaid/EPSDT expenditures. The lack of Medicaid reimbursements for all EPSDT health and supportive services should also be considered.

As previously indicated, expenditures exceeded the revenue sources available to support the collaborative effort. While this strongly suggests error in reporting, the possibility cannot be dismissed that projects may have reached beyond the revenue sources reported to sustain the implementation of the Head Start/EPSDT program. For example, some projects may have failed to report (in the Income Sources Form) monies spent on the effort which were not specifically earmarked for Head Start/EPSDT, but which were, nonetheless, used for this purpose. This would suggest that in certain cases projects were willing to sacrifice other program objectives or activities to ensure maintenance of the effort. It can be speculated that many of the demonstration projects used monies normally associated with the categorical Head Start grant to meet the financial obligations of the collaboration effort incurred beyond the supplemental grant monies available.

Other analysis shows that Region VI expended $108,515 on the collaborative effort--the most reported among all regions and IMPD programs. Regions I, IV, V, and X all reported EPSDT expenditures in the range of $90,000. Region VII reported somewhat less at $70,171, with Region VIII following at $37,088. Regions III, IX, and the IMPD projects indicated expenditures from $16,000 to $17,000. The least amount reported was in Region II - $14,516. Of course, much of this relates directly to the number of projects reporting. It is, therefore, not clearly discernible whether this trend would have prevailed had the majority of projects reported.

Individually, Cook County of Chicago, Illinois reported spending $16,419 on the collaborative effort. This was highest among the demonstration projects. On the other hand, Nett Lake, Minnesota reported a nominal amount of $45--lowest among all projects.

2. Analysis of Findings (Table XIX)

Table XIX indicates that 48% ($316,399) of all monies spent by the demonstration projects on the collaborative effort was attributable to direct costs. This indicates that nearly fifty cents of every dollar went to salaries of staff directly involved in EPSDT medical services; to the cost of supplies used in the course of providing direct health

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION I						
Mass:						
Gloucester	$11,325.00	$ 9,626.00	$ 1,250.00	$ 449.00	213	$ 53.00
Pittsfield	19,361.97	5,214.77	8,522.71	5,624.49	160	121.00
Greenfield	3,746.39	2,866.41	633.65	246.33	310	12.00
Total	$34,433.36	$17,707.18	$10,406.36	$ 6,319.82	683	$ 50.00
Vermont:						
Newport	$10,150.00	$ 2,000.00	$ 7,226.96	$ 923.04	181	$ 56.00
Winooski	10,000.00	4,736.10	1,000.00	4,263.90	242	41.00
Total	$20,150.00	$ 6,736.10	$ 8,226.96	$ 5,186.94	423	$ 48.00
Connecticut:						
Danielson	$25,632.21	$ 7,139.31	$ 9,148.80	$ 9,344.10	158	$162.00
Jewett City	13,886.00	1,015.00	8,609.00	4,262.00	268	52.00
Total	$39,518.21	$ 8,154.31	$17,757.80	$13.606.10	426	$ 93.00
Regional Totals	$94,101.57	$32,597.59	$36,391.12	$25,112.86	1,532	$ 61.00
REGION II						
New York:						
Watertown	$ 9,237.39	$ 2,319.19	$ 866.63	$ 6,051.57	216	$ 43.00
New Jersey:						
Orange	$ 5,278.31	$ -0-	$ -0-	$ 5,278.31	302	$ 18.00
Regional Totals	$14,515.70	$ 2,319.19	$ 8,666.63	$11,329.88	518	$ 28.00
REGION III						
Maryland:						
Salisburg	$10,775.00	$ 2,871.00	$ 3,155.75	$ 4,748.25	357	$ 30.00
Virginia:						
Roanoke	5,567.20	5,567.20	-0-	-0-	558	$ 10.00
Total	$ 5,567.20	$ 5,567.20	$ -0-	$ -0-		
Regional Totals	$16,342.20	$ 8,438.20	$ 3,155.75	$ 4,748.25	915	$ 18.00

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION IV						
Mississippi:						
Starkeville	$12,040.00	$ 5,228.00	$ 3,890.00	$ 2,922.00	413	$ 29.00
Yazoo	21,520.00	18,427.00	3,093.00	-0--	447	48.00
Total	$33,560.00	$23,655.00	$ 6,983.00	$ 2,922.00	860	$ 39.00
Tennessee:						
Kingston	$ 8,062.46	$ 4.149.17	$ 2,333.67	$ 1,579.62	226	$ 36.00
Alabama:						
Carrollton	$ 7,975.70	$ 7,109.70	$ 866.00	$ -0-	257	$ 31.00
Georgia:						
Monticello	$13,239.01	$11,580.01	$ 1,439.00	$ 220.00	68	$195.00
Gainesville	13,300.00	2,772.00	5,977.00	4,551.00	900	15.00
Total	$26,539.01	$14,352.01	$ 7,416.00	$ 4,771.00	968	$ 27.00
Kentucky:						
Frankfort	$20,000.00	$17,563.00	$ 1,252.00	$ 1,185.00	1,530	$ 13.00
Regional Totals	$96,137.17	$66,828.88	$18,850.67	$10,457.62	3,841	$ 25.00
REGION V						
Illinois:						
Cook County	$61,419.00	$45,812.00	$ 8,342.00	$ 7,265.00	652	$ 94.00
Waukegan	23,946.00	7,617.00	9,298.00	7,031.00	226	106.00
Total	$85,365.00	$53,429.00	$17,640.00	$14,296.00	878	$ 97.00
Wisconsin:						
Madison	$ 5,000.00	$ 1,180.00	$ 3,700.00	$ 120.00	508	$ 10.00
Superior	5,503.00	-0-	-0-	5,503.00	557	10.00
Total	$10,503.00	$ 1,180.00	$ 3,700.00	$ 5,623.00	1,065	$ 10.00
Regional Totals	$95,868.00	$54,609.00	$21,340.00	$19,919.00	1,943	$ 49.00

HEAD START/EPSDT EXPENDITURES RE:
DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION VI						
Texas:						
Witchita Falls	$ 7,946.57	$ 4,436.92	$ 994.46	$ 2,515.19	208	$ 38.00
San Antonio	5,904.05	5,000.00	797.55	106.50	732	8.00
Amarillo	9,553.00	[illegible],000.00	2,108.00	2,445.00	732	13.00
Total	$23,403.62	$14,[illegible]36.92	$ 3,900.01	$ 5,066.69	1,672	$ 14.00
Arkansas:						
Hot Springs	$24,978.84	$ 8,252.16	$ 115.00	$16,611.68	136	$184.00
Louisiana:						
Alexandria	$14,387.00	$10,586.00	$ 550.00	$ 3,251.00	741	$ 19.00
New Mexico:						
Carlsbad	$ 8,503.71	$ 5,000.56	$ 2,208.15	$ 1,295.00	189	$ 45.00
Oklahoma:						
Watonga	$37,242.00	$ 5,000.00	$ 8,050.00	$24,192.00	141	$264.00
Regional Totals	$108,515.17	$43,275.64	$14,823.16	$50,416.37	2,879	$ 38.00
REGION VII						
Missouri:						
Joplin	$ 6,175.00	$ 2,013.97	$ 4,157.13	$ 3.90	128	$ 48.00
Kirkville	5,627.00	627.00	3,146.00	1,854.00	137	41.00
Appleton	5,000.00	12.00	4,777.79	210.21	181	28.00
Total	$ 16,802.00	$ 2,652.97	$12,080.92	$ 2,068.11	446	$ 38.00
Kansas:						
Horton	$ 5,148.35	$ 40.00	$ 4,374.32	$ 734.03	269	$ 19.00
Girard	48,221.00	22,662.00	23,154.00	2,405.00	599	81.00
Total	$ 53,369.35	$22,702.00	$27,528.32	$ 3,139.03	868	$ 61.00
Regional Totals	$ 70,171.35	$25,354.97	$39,609.24	$ 5,207.14	1,314	$ 53.00

HEAD START/EPSDT EXPENDITURES RE:
DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION VIII						
Colorado:						
La Junta	$ 10,631.00	$ 10,488.00	$ 143.00	$ -0-	205	$ 52.00
Pueblo	14,855.00	10,000.00	3,900.00	955.00	357	42.00
Trinidad	11,602.00	5,960.60	4,032.00	1,609.40	145	80.00
Total	$ 37,088.00	$ 26,448.60	$ 8,075.00	$ 2,564.40	707	$ 52.00
Regional Totals	$ 37,088.00	$ 26,448.60	$ 8,075.00	$ 2,564.40	707	$ 52.00
REGION IX						
Hawaii:						
Kauai	$ 16,995.00	$ 6,626.00	$ 8,502.00	$ 1,867.00	158	$108.00
Regional Totals	$ 16,995.00	$ 6,626.00	$ 8,502.00	$ 1,867.00	158	$108.00
REGION X						
Oregon:						
La Grande	$ 11,938.94	$ -0-	$ 161.25	$11,777.69	49	$244.00
Eugene	46,629.65	15,782.65	11,601.00	19,246.00	222	210.00
Salem	15,599.00	5,500.00	9,175.00	924.00	326	48.00
Clatskanie	15,361.00	12,176.00	3,185.00	-0-	151	102.00
Total	$ 89,528.59	$ 33,458.65	$24,122.25	$31,947.69	748	$120.00
Regional Totals	$ 89,528.59	$ 33,458.65	$24,122.25	$31,947.69	748	$120.00
IMPD PROGRAMS						
Minnesota:						
White Earth	$ 44.65	$ -0-	$ 44.65	$ -0-	50	-
Montana:						
Flat Head	11,152.00	10,734.00	418.00	-0-	45	$245.00
Nabraska:						
Niobraro	$ 5,924.00	$ 5,708.00	$ 216.00	$ -0-	35	$169.00
Total IMPD	17,120.65	16,442.00	678.65	-0-	130	$132.00
GRAND TOTAL	$656,383.40	$316,398.72	$176,414.47	$163,570.21	14,685	$ 45.00

services; and to other areas directly ascribable to health services rendered to EPSDT participants. This finding supports a previous statement relative to the project staff administering direct health services and thereby, contributing to the low percentage in the use of Medicaid/EPSDT dollars.

Further analysis shows that a considerable share of monies spent was for supportive and administrative activiites--$176,414 and $163,570 respectively. Thus, 27 cents (27%) of every dollar was spent on supportive activities and 25 cents (25%) of every dollar went toward administrative functions.

It seems that adequate monies were generally provided by the project toward the objective of having Head Start assist the EPSDT program in delivering health-related supportive services to Medicaid eligible children in the community. Administrative costs, however, seem to be disproportionately high when considering the major objective of the program: to reach and provide EPSDT services to as many Medicaid eligible children as possible. This may be the result of requisite start-up activities for the program, e.g., staff orientation to EPSDT, meetings between Head Start staff and local Medicaid/EPSDT agencies, familiarization with and completion of data survey instruments, etc. by comparison, there were, of course, difference among regions and IMPD programs regarding the distribution of direct, supportive, and administrative costs and its proximity to the aggregate distribution of the universe (reference Exhibit VIII). For example, Region II reported that an inordinate amount of monies, approximately 75 cents of every dollar, was spent on administrative tasks, leaving very few monies for other services. Conversely, the IMPD projects indicated that nothing was expended for administrative activities. Rather, 96% of all expenditures were for direct services, with the remaining 4% going to supportive services. In this instance, it must be assumed that there is some error in reporting, since it is highly improbable that such a low percentage of administrative expenses would have been incurred.

A high incidence of direct services expenditures was also prevalent among Regions IV, V, and VIII-70%, 75% and 71%. Region I reported a low of 16% for direct services. The remaining regions averaged around 40%.

EXHIBIT VIII

DISTRIBUTION OF HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS

Region	Total Expend.-H.S.EPSDT	Direct	Supportive	Administrative
I % Distribution	94,101 100%	32,597 35%	36,391 39%	25,113 26%
II % Distribution	14,515 100%	2,318 16%	867 6%	11,330 79%
III % Distribution	16,342 100%	8,438 52%	3,156 19%	4,748 28%
IV % Distribution	96,138 100%	66,830 70%	18,851 20%	10,457 10%
V % Distribution	95,868 100%	54,609 57%	21,340 22%	19,919 21%
VI % Distribution	108,516 100%	43,277 40%	14,823 14%	50,416 46%
VII % Distribution	70,171 100%	25,355 36%	39,609 56%	5,207 8%
VIII % Distribution	37,088 100%	26,449 71%	8,075 22%	2,564 7%
IX % Distribution	16,995 100%	6,626 39%	8,502 50%	1,867 11%
X % Distribution	89,529 100%	33,459 37%	24,122 27%	31,948 36%
IMPD % Distribution	17,121 100%	16,442 96%	679 4%	- -
Aggregate Total % Distribution	656,384 100%	316,400 48%	176,415 27%	163,569 25%

NOTE: Information is based on a total of 45 projects reporting.

In the supportive cost category, Region VII was highest, with expenditures amounting to 56% of the total. Region IX and I then follow with 50% and 39% respectively. With the exception of IMPD programs, Region II was lowest in support service expenditure with only a 6% allocation and Region VII was moderately low at 14%. Other regions expended 20% or more for supportive service activities.

Administrative expenditures outside of Region II ranged from 7% to 46%. Region VI reported 46% while Regions VII, IV, and IX indicated considerably lower percentages at 8%, 10%, and 11%. An average of 28 cents for every dollar was spent by the remaining regions, I, III, V and X, on administrative duties.

The average annual per child cost among all regions and IMPD programs was reported at $45.00. This figure appears to be extremely low since the national annual per child cost of health services to AFDC Medicaid recipients was assessed at $165 per child* Again, one can speculate that the low average may be attributable to under reporting by the demonstration projects of monies used to support the collaborative effort. This, of course, bears directly on the per child cost of health and related services.

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*This figure was taken from Health Start: Final Report of the Evaluation of the Second Year Program, December 1973. pg. VII-14. The calculation was based on information from "National Health Expenditure, 1969-1971," Social Security Bulletin, January 1972.

Reporting among projects regarding per patient cost varied considerably. Data from Table XIX shows that per child cost of health and related services for Head Start/EPSDT ranged from eight dollars to $264.00 among the various projects. These amounts were reported by Opportunities Development Corporation of San Antonio, Texas and Opportunities, Inc. of Watonga, Oklahoma, respectively. Both these projects are Region VI affiliates.

The IMPD programs indicated the highest per child cost at $132.00. Regions X and IX followed, reporting $120.00 and $108.00, respectively. The lowest per child cost was reported by Region III - $18.00

Data from Table XIX also shows that considerably low per child costs were reported by Regions IV and II - $25.00 and $28.00 The remaining regions (I, VI, VII, and VIII) reported amounts closer to the overall average per child cost.

3. Conclusions

a. Expenditures for Head Start/EPSDT varied from project to project; about 75% of the total EPSDT expenditures for all regions and IMPD programs originated from the Head Start/EPSDT supplemental grant. Contributions from other sources were minimal

b. Medicaid/EPSDT only accounted for 6% of all EPSDT expenditures. It appears that many projects are providing requisite EPSDT screening services to collaboration participants themselves. Lack of providers, failure to reimburse for certain services in accordance with the EPSDT state plan. et al. may be contributing factors to the low percentage of Medicaid/EPSDT expenditures.

c. Analysis of the data indicated that programs extended beyond the supplemental grant to support the collaborative effort, which suggests that the supplemental grant alone was not sufficient to sustain the implementation of Head Start/EPSDT.

d. Overall, 48% of all dollars expended by the demonstration projects for the EPSDT program was for direct health services, with 27% and 25% attributable to supportive costs and administrative costs, respectively.

e. Projects allocated adequate monies for supportive services to satisfy the objective of soliciting as many Medicaid eligible children as possible for participation in the program. But it appears that more discretion could have been exercised regarding the relatively high cost of administrative services, in view of the overall objective of reaching and serving as many children as possible.

f. Per child costs fluctuated considerably among the projects. The average per child cost, however, was assessed at $45.00.

4. Policy Considerations

a. The demonstration projects could begin to take a serious look at where they are spending money relative to fullfilling the objectives of Head Start/EPSDT. Certainly if one of the primary objectives of the program is to reach and provide supportive services to Medicaid eligible children, then programs must identify, within the total program concept, the monies needed to accomplish this objective. Thus, it is likely that more should be spent in this area. Expenditures in other areas of less priority could, by contrast, be held to a minimum.

b. Programs could begin to become more cost conscious. They could consider alternative ways of monitoring EPSDT expenditures other than by line-items expenditure, particularly in light of emphasis (in the second year program) on projects qualifying as vendors for third-party reimbursements. In negotiating EPSDT purchase of service agreements, many state and/or local Medicaid agencies require that costs be stratified by direct and administrative services. In some instances, a determination of supportive costs is requested. This is done for purposes of the state ascertaining the services for which they will reimburse. A consideration, therefore, is that projects would adopt a system which begins to meet this need. Such a system not only provides a means for identifying costs for reimbursement requirements, but can also be useful as a management tool for budgeting and planning purposes. Moreover, it provides management with the requisite information as to dollar spending relative to program objectives and further establishes the parameters necessary for any decision-making as to the most cost-effective approach for reaching these objectives.

c. In light of the uncertainty of future collaborative effort funding, stronger emphasis will be placed on programs to take full advantage, wherever possible, of all Medicaid/EPSDT reimbursable services. Programs could also be encouraged to make every attempt to secure vendor recognition.

d. Because of the unreliability of cost/revenue data, more emphasis could be placed on the retrieval of this information in the proposed second year evaluation, particularly in light of the programs poor response rate and apparent misunderstanding of what was requested. A closer look at the impact of EPSDT Medicaid dollars on the collaborative effort might be a key consideration.

C. MEDICAID INVOLVEMENT IN THE PAYMENT OF EPSDT SERVICES TO MEDICAID CERTIFIED PARTICIPANTS

Data from table XX presents information concerning Medicaid's involvement in the payment for EPSDT services received by Medicaid certified participants. Information is arrayed by the particular health service category for Head Start and non-Head Start enrollees. Reporting is based on information obtained from the Health Care Encounter Form relative to the 24 selected projects. No attempt was made, here, to assess the dollar value of Medicaid payments, as this information could not be retrieved from the aforementioned form. Rather, the data focuses on the units of health services received by Medicaid certified participants in which Medicaid was involved as a payment source. This finding is then expressed as a percentage to the whole of units of health services received which were paid for by Medicaid, in whole or part.

1. Analysis of Findings

Data indicated that 51% of all health services received by the Medicaid certified population--both Head Start and non-Head Start participants--among the selected projects was paid for, in whole or part, by Medicaid. Surprisingly, non-Head Start children had a greater percentage (63%) of their health services paid for by Medicaid than did Head Start children (50%).

MEDICAID INVOLVEMENT IN THE PAYMENT OF UNITS OF EPSDT SERVICES FOR MEDICAID CERTIFIED PARTICIPANTS BY HEALTH SERVICE

Table XX

Health Service	Total Units of Services Received By Med. Certified Children	Units of Services Received by Med. Cert. Children		Units of Service Paid for by Medicaid				% of Services Received Paid for by Medicaid		Average % for HS & NH
				HS		NHS				
		HS	NHS	Yes	No	Yes	No	HS	NHS	
Medical	3,900	3,424	476	2,853	571	457	19	83%	96%	85%
Dental	3,298	2,970	328	2,198	772	319	9	74%	97%	76%
Mental Health	1,428	1,406	22	206	1,200	5	17	14%	23%	15%
Nutritional	3,430	3,001	429	117	2,884	7	422	4%	2%	4%
Total	12,056	10,801	1,255	5,374	5,427	788	467	50%	63%	51%

NOTE: Figures do not represent numbers of Medicaid children receiving health services. Rather, they represent the units of health services received (within each category) by Medicaid certified participants.

This followed throughout each of the major categories of health service, with the exception of nutritional services. It is speculated that this trend was a result of less contact by the programs with the non-Head Start certified children regarding the full range of EPSDT mandated services and/or the probability of needed follow-up treatment. Medicaid in many instances does not reimburse for the full range of health services. Because Head Start Medicaid children are more likely to be the recipients of total health services as opposed to non-Head Start Medicaid certified children, the greater the possibility becomes for Medicaid *not to be* involved in the payment process.

Data also indicates that Medicaid was most responsive in participating in the payment for medical and dental services administered to Medicaid certified children. Medicaid's involvement as a payment source in these areas was reported at 85% and 76%, respectively. On the other hand, Medicaid's involvement in the payment for mental and nutritional health services was considerably low at 15% and 4%.

2. Conclusions

a. While the effectiveness of EPSDT Medicaid in terms of its dollar contribution to the collaborative effort cannot be assessed, it is concluded that the Head Start projects were reasonably effective in involving Medicaid in the payment of reimbursable services in accordance with their respective EPSDT State Plans.

b. EPSDT Medicaid as a viable source for the payment of Medical and Dental services appears adequate, but falls considerably short for the payment of mental health and nutritional services.

3. Policy Considerations

a. Head Start projects could be encouraged, wherever possible, to maximize their efforts to involve Medicaid in the payment of EPSDT services, particularly where such services are reimbursable according to the EPSDT State Plan

b. Projects could also be encouraged to negotiate with state/local Medicaid agencies for reimbursement rates which more reasonably reflect the actual costs or the going community rate for providing EPSDT services. This could possibly increase the number of Medical providers willing to participate in the EPSDT effort who were reluctant to do so before because of low remuneration (from Medicaid) for services rendered.

c. Projects could be encouraged to negotiate with state/local Medicaid agencies for reimbursement for the full range of EPSDT services provided. e.g. supportive services such as transportation. This would reduce the cost to Head Start for the implementation and maintenance of the collaborative effort and allow these dollars to be reprogrammed for other priority considerations relative to the collaboration.

D. ASSESSED VALUE OF HEAD START/EPSDT HEALTH SERVICES FOR SELECTED PROJECTS

Information obtained applicable to the assessed value of services regarding medical, dental, mental health, nutritional services, etc., proved to be unreliable. Most projects experienced difficulty in providing this information. There was apparent confusion among the demonstration projects as to the exact meaning of assessed value of services.

To highlight this confusion in this area, one project reported the assessed value of all services received at over $4,000,000. This was more than the total amount reported by all other selected projects combined. Other projects also reported unreasonable amounts.

Information germane to this area was obtained from the Health Care Encounter Form for the selected projects. The assessed value of services was to be reported as the cost that would normally be incurred by Head Start for the provision of EPSDT health services to Medicaid certified children. This amount, which would presumably exceed the total amount of monies paid by Medicaid for reimbursable EPSDT services, would constitute the additional dollars needed from Medicaid to support the collaborative effort.

Conclusions

With the apparent confusion/difficulty most of the selected projects had in gathering information on the assessed value of Head Start/EPSDT services, there were no discernible conclusions reached on this aspect of the study.

Policy Considerations

a. Because of the apparent confusion caused by the use of such terminology as "assessed value of services", it is suggested that this phrase be dropped for purposes of the proposed second year evaluation. Rather, it seems only necessary to request the demonstration projects to report the amount of monies they spend, beyond those reimbursed by Medicaid, on EPSDT services rendered to Medicaid certified participants. This will serve to indicate the total amount of monies needed from Medicaid to fully support the collaborative effort relative to the Medicaid certified population.

b. While most projects do not maintain their accounting records in this manner, it should not be difficult to collect this information. An accounting of the services received by the Medicaid certified children and the related reimbursement reates allowed by Medicaid for same would form the basis for calculation. This information could be retrieved from each of the demonstration projects via the proposed revised End-of-Year-Status Form.

c. Where site visits are made, a more intensive look at the recordkeeping systems and the respective reimbursement plans could be conducted to retrieve this information.